

98TH CONGRESS  
1st Session

SENATE

REPORT No.  
98-145

VETERANS' HEALTH CARE AND PROGRAMS  
IMPROVEMENT ACT OF 1983

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REPORT

OF THE

COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE

TO ACCOMPANY

S. 578



MAY 23 (legislative day, MAY 16), 1983.—Ordered to be printed

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# Calendar No. 223

98TH CONGRESS }  
1st Session }

SENATE

{ REPORT  
No. 98-145

## VETERANS' HEALTH CARE AND PROGRAMS IMPROVEMENT ACT OF 1983

MAY 23 (legislative day, MAY 16), 1983.—Ordered to be printed

Mr. SIMPSON, from the Committee on Veterans' Affairs,  
submitted the following

### REPORT

[To accompany S. 578]

The Committee on Veterans' Affairs to which was referred the bill (S. 578) to amend title 38, United States Code, to provide for adult day health care services for veterans, to authorize the Veterans' Administration to administer a community residential care program, to establish a presumption of service-connection for former prisoners of war suffering from dysthymic disorder and to revise and clarify eligibility for reimbursement of expenses of travel for Veterans' Administration health care, having considered the same, reports favorably thereon with an amendment in the nature of a committee substitute, and an amendment to the title, and recommends that the bill, as amended, do pass.

### COMMITTEE AMENDMENTS

The amendments are as follows:

Strike out all after the enacting clause as follows:

[That (a) this Act may be cited as the "Veterans' Health Care and Programs Improvement Amendments of 1983".

[(b) Except as otherwise expressly provided, whenever in this Act an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

### [TITLE I—ADULT DAY HEALTH CARE SERVICES PILOT PROGRAM

[SEC. 101. (a) Chapter 17 is amended by adding at the end thereof the following new subchapter:

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## ["SUBCHAPTER VIII—ADULT DAY HEALTH CARE SERVICES PILOT PROGRAM

### ["§ 671. Purpose

["The purpose of this subchapter is to authorize the Administrator to (1) provide, as an alternative to institutionalization in a Veterans' Administration hospital, nursing home or domiciliary, certain day health care services which would enable veterans to reside in a supportive home environment while receiving the most appropriate and best possible health care during daytime hours when their families may be unavailable to afford the necessary care and attention, and (2) determine the medical efficacy and cost effectiveness of such services.

### ["§ 672. Definition

["For the purposes of this subchapter, the term 'adult day health care services' shall include ambulatory medical care provided by physicians, nurses and/or other health-care personnel, and may include—

- ["(1) physical therapy and speech therapy;
- ["(2) social work;
- ["(3) recreational therapy;
- ["(4) midday meals; and
- ["(5) such other medical or rehabilitative services as

["the Administrator may determine to be necessary to provide an effective and economical alternative to extended or long-term institutional care.

### ["§ 673. Adult day health care services

["(a) In order to carry out the purposes of this subsection, the Administrator, in accordance with regulations which the Administrator shall prescribe, may conduct a pilot program under which the Administrator may furnish, in a congregate ambulatory setting at Veterans' Administration medical facilities during normal daytime working hours, adult day health care services to any veteran eligible for hospital or nursing home care under section 610 of this title. Such pilot program shall be planned, designed and conducted so as to demonstrate any medical efficacy and cost effectiveness that may result from furnishing services through adult day health care programs rather than through institutionalization in a Veterans' Administration hospital, nursing home or domiciliary.

["(b) In carrying out the pilot program provided for by this subchapter, the Administrator may not furnish adult day health care services after September 30, 1987.

["(c) In order to effectuate the authority provided for in this subchapter, and to carry out such leasing of facilities, or construction or conversion of Veterans' Administration medical facilities as the Administrator may find necessary in furnishing the services provided for under this subchapter, the Administrator may expend not more than \$35,000,000 in each of the fiscal years 1984 through 1987.

### ["§ 674. Reports

["The Administrator shall include in the annual report to the Congress required by section 214 of this title a comprehensive report on the administration and effectiveness of this subchapter in meeting its stated purpose, including such recommendations for additional legislation as the Administrator considers necessary."

["(b) The table of sections at the beginning of such chapter is amended by adding at the end thereof the following:

## ["SUBCHAPTER VIII—ADULT DAY HEALTH CARE SERVICES PILOT PROGRAM

["661. Purpose.

["662. Definition.

["663. Adult day health care services.

["664. Reports."

## ["TITLE II—COMMUNITY RESIDENTIAL CARE

["SEC. 201. The purpose of this title is to authorize a program under which veterans who wish to participate and who are being furnished care under chapter 17 of title 38, United States Code, may be assisted by the Veterans' Administration in their return to the community residential facilities, and to ensure that such facilities provide a safe and healthful environment at a reasonable cost to the veteran.

["SEC. 202. (a) Subchapter II of chapter 17 is amended by adding at the end thereof the following new section:

**["§ 620B. Transfers for community residential care**

["(a) For the purpose of this section, the term 'residential care facility' means any dwelling or other facility which provides, at a minimum, room, board, limited personal care, and limited supervision.

["(b) The Administrator shall promulgate regulations to ensure the health, welfare, and safety of veterans in those residential care facilities for which an election has been made on behalf of the residential care facility to participate in the program authorized by this section.

["(c) Subject to subsection (g) the Administrator may assist any veteran who is being furnished hospital, domiciliary, nursing home care, or medical services on an outpatient basis by the Administrator by referring him or her for placement in a residential care facility.

["(d) The cost of any care or services provided under this subsection shall be the obligation of the veteran pursuant to his or her agreement with the residential care facility. The cost of that care shall not exceed the reasonable rate determined pursuant to this section.

["(e) No veteran will be provided assistance in obtaining placement in any residential care facility under this section unless such facility is approved by the Administrator as being capable of providing adequate personal home care and services to the veteran. The Administrator's approval shall be upon the basis of standards the Administrator shall prescribe. Such standards shall provide—

["(1) health and safety criteria;

["(2) guidelines by which reasonable rates for community residential care may be determined, giving consideration to such factors as (A) the level of care, supervision, and other services to be provided, (B) the cost of goods and services in the geographical area in which the facility is located, and (C) comparability with other facilities providing similar services;

["(3) criteria for determining the necessary resources for a residential care facility to provide an appropriate level of personal services to veterans; and

["(4) such other criteria as the Administrator determines are appropriate to ensure the well-being of veterans placed in residential care facilities pursuant to this section.

["For the purpose of this subsection, the Administrator may, upon advice of the Chief Medical Director, delegate authority to Veterans' Administration medical center directors to promulgate local standards necessary to meet requirements of State law or local ordinance in addition to those prescribed under this subsection.

["(f) The Administrator shall provide for periodic inspection of residential care facilities to meet the purposes of this section and to determine compliance with the standards established under subsection (e) of this section.

["(g) If the Administrator determines that in the case of any residential care facility, such facility is not in compliance with the regulations promulgated under subsection (b) of this section, the Administrator may—

["(1) cease to refer veterans to the noncomplying facility, and

["(2) assist in removing a veteran from a noncomplying facility, with the permission of the veteran, or the permission of the person or entity authorized by law to make that decision.

["(h) Any action taken pursuant to the authority of subsection (g) of this section with regard to a veteran in a residential care facility shall be in accordance with regulations which the Administrator shall prescribe. Such regulations shall provide for reasonable notice and, upon request made on behalf of such residential care facility, a hearing before any action authorized by subsection (g) is taken."

["(b) The table of sections at the beginning of chapter 17 is amended by adding after the item relating to section 620A the following new item:

["620B. Transfers for community residential care."

**[[TITLE III—PRESUMPTION CONCERNING DYSTHYMIC DISORDER**

[SEC. 301. Section 312(b) is amended by—

["(a) inserting after paragraph (7) the following new paragraph:

["(8) dysthymic disorder (or depressive neurosis),"

["(b) redesignating paragraphs (8) and (9) as paragraphs (9) and (10), respectively.

**[[TITLE IV—BENEFICIARY TRAVEL**

[SEC. 401. Section 111(e)(2) is amended by—

["(1) redesignating clauses (B) and (C) as clauses (C) and (D), respectively, and

["(2) inserting after clause (A) the following new clause (B):

["(B) for the first \$10 (or such lesser amount as the Administrator shall by regulation prescribe in order to minimize hardship in cases of veterans whose disabilities necessitate frequent travel to a Veterans' Administration facility for care) of the cost of travel to and from Veterans' Administration facilities (as defined in section 601(4) of this title) when a person receives medical care at such facilities. This subparagraph shall not apply when such care is provided (i) through a program of adult day health care services under subchapter VIII of chapter 17 of this title to a veteran of World War I, (ii) to a veteran for a service-connected disability, (iii) to a veteran with a service-connected disability rated at 50 per centum or more, or (iv) for medically indicated ambulance transportation when authorized by the Administrator;".

#### 【TITLE V—EFFECTIVE DATE

【Sec. 501. The amendments made by this Act shall be effective on October 1, 1983.】

and insert in lieu thereof the following:

That (a) this Act may be cited as the "Veterans' Health Care and Programs Improvement Act of 1983".

(b) Except as otherwise expressly provided, whenever in this Act an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be considered to be made to section or other provision of title 38, United States Code.

#### TITLE I—VETERANS' ADMINISTRATION HEALTH CARE PROGRAMS

##### ADULT DAY HEALTH-CARE SERVICES

SEC. 101. (a) Section 620 is amended—

(1) by adding at the end of the catchline a semicolon and "adult day health care pilot program";

(2) in subsection (a), by striking out "the jurisdiction" and inserting in lieu thereof "the direct jurisdiction";

(3) in subsection (b), by inserting "or adult day health care" after "nursing home care";

(4)(A) by redesignating subsection (e) as subsection (f), and inserting "(1)" before "For"; and

(B) by adding at the end of subsection (f) (as so redesignated) the following new paragraph:

"(2) For the purposes of this section, the term 'adult day health care' means health and social services furnished to individuals in congregate settings during daytime hours for the purpose of enabling such individuals to reside in supportive home environments rather than in nursing home care facilities. Such health and social services may include medical services furnished on an outpatient or ambulatory basis, midday meals, and transportation, including transportation between home and the facility providing such health and social services."; and

(5) by inserting after subsection (d) the following new subsection:

"(e)(1)(A) Subject to subparagraphs (B) and (C) of this paragraph, the Administrator may conduct a pilot program of adult day health care under which the Administrator, in the case of a veteran described in paragraph (1) of subsection (a) of this section who is eligible for transfer pursuant to such subsection, may transfer such veteran for the purpose of such veteran being furnished such care, at the expense of the United States, to any public or private facility not under the direct jurisdiction of the Administrator which furnishes such care. Such care may not be furnished under this paragraph at the expense of the United States for more than 6 months in the aggregate in connection with any one transfer, except (i) in the case of a veteran whose hospitalization was primarily for a service-connected disability, or (ii) where in the judgment of the Administrator a longer period is warranted in the case of any other veteran.

"(B)(i) The terms and conditions set forth in subsections (b) and (c) of this section applicable (I) to the transfer or admission of veterans to institutions for nursing home care under this section, and (II) to contracts for the provision of such care, respectively, shall apply to the furnishing of adult day health care under this subsection.

"(ii) The authorities provided in the final sentence of subsection (a) of this section and in the first two sentences of subsection (d) of this section with respect to fur-



nishing nursing home care to certain veterans shall be available to the Administrator for the furnishing of adult day health care to such veterans under this subsection.

"(C) Adult day health care may be furnished to a veteran under this subsection only if the Administrator determines that the cost per week of such care will be less than the lesser of the cost per week of furnishing such veteran nursing home care under this section or the cost per week of furnishing such veteran nursing home care in a facility under the direct jurisdiction of the Administrator.

"(2) In exchange for the United States being relieved from paying all or part of the expenses that would otherwise be paid by the United States under paragraph (1) of this subsection to a facility providing care to an eligible veteran under such paragraph, the Administrator may, pursuant to a contractual arrangement with such facility, provide such facility with inkind assistance through Veterans' Administration employees and the sharing of other Veterans' Administration resources. In any such contractual arrangement, the Administrator may agree to provide such assistance for utilization solely in the furnishing of adult day health care and only to the extent that the cost of such assistance is equal to or less than the amount of the expenses that, under such arrangement, the United States will be relieved from paying.

"(3) The Administrator may, as part of the pilot program under paragraph (1) of this subsection, establish and conduct at each of four geographically dispersed hospital or outpatient facilities over which the Administrator has direct jurisdiction a program of adult day health care for veterans who are eligible for such care under paragraph (1) of this subsection.

"(4) To the extent that the pilot program authorized by this subsection is carried out, the Administrator—

"(A) shall plan and conduct such program and a study thereof so as to provide for the assessment and demonstration of (i) any medical efficacy and cost-effectiveness of furnishing adult day health care as an alternative for nursing home care, and (ii) the comparative advantages and disadvantages of providing such care through facilities not under the direct jurisdiction of the Administrator and facilities that are under such jurisdiction; and

"(B) may not furnish adult day health care under this subsection after September 30, 1987.

"(5) In the annual reports to the Congress for each of fiscal years 1984, 1985, and 1986 as required by section 214 of this title, the Administrator shall include detailed descriptions of the activities carried out under this subsection. Not later than December 1, 1986, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing—

"(A) the results of any study conducted under paragraph (4)(A) of this subsection; and

"(B) any recommendations for legislative and administrative action that the Administrator considers appropriate."

(b) The table of sections at the beginning of chapter 17 is amended by amending the item relating to section 620 to read as follows:

"620. Transfers for nursing home care; adult day health care pilot program."

#### VIETNAM-ERA VETERANS' READJUSTMENT ISSUES

SEC. 102. Section 612A is amended—

(1) in subsection (a), by striking out "September 30, 1984" and inserting in lieu thereof "September 30, 1985";

(2) in subsection (g)(1)—

(A) by striking out "September 30, 1984" and inserting in lieu thereof "September 30, 1985"; and

(B) by striking out "October 1, 1984" and inserting in lieu thereof "October 1, 1985"; and

(3) in subsection (g)(2)—

(A) by striking out "April 1, 1984" and inserting in lieu thereof "September 30, 1984";

(B) by striking out "on" after "report" and inserting in lieu thereof "containing (A) a description of"; and

(C) by inserting before the period a comma and "and (B) the Administrator's evaluation of the effectiveness of the readjustment counseling services provided pursuant to this section in helping to meet the readjustment needs of veterans who served on active duty during the Vietnam era, with partic-

ular reference to identification and treatment of post-traumatic stress disorder".

SEC. 103. (a) The Administrator of Veterans' Affairs shall design and conduct a comprehensive study of the prevalence, incidence, and effects of post-traumatic stress disorder and related problems in readjusting to civilian life among veterans who served on active duty during the Vietnam era, with particular emphasis on those who have service-connected disabilities and those who served in the Republic of Vietnam or elsewhere in the Vietnam theater of operations and with specific reference to women veterans.

(b) Not later than March 1, 1985, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the results of the study required by subsection (a). Such report shall contain (1) a description of the results of the study, (2) information regarding the capability of the Veterans' Administration to provide treatment to the number of veterans identified in such study as suffering from post-traumatic stress disorder and related readjustment problems, (3) a description of the policy and procedures of the Veterans' Administration with respect to providing disability compensation for such disorder and problems, (4) a description of the activities of the Veterans' Administration to attempt to coordinate Veterans' Administration health-care and compensation programs with respect to post-traumatic stress disorder, and (5) such recommendations for administrative or legislative action, or both, as the Administrator considers appropriate in light of the study results.

(c) For the purposes of this section, the terms "veteran", "service-connected", "active duty", and "Vietnam era" shall have the meaning provided in section 101 (2), (16), (21), and (29), respectively, of title 38, United States Code.

#### PREVENTIVE HEALTH-CARE SERVICES

SEC. 104. (a) Section 601(6)(A)(i) is amended by inserting "(in the case of a person otherwise receiving care or services under this chapter), preventive health-care services as defined in section 662 of this title" after "podiatric services".

(b) Section 661 is amended—

(1) by striking out "under which the Administrator may attempt to" and inserting in lieu thereof "in order to help";

(2) by inserting after "certain" the first place it appears "veterans otherwise being furnished care or services under this chapter, including";

(3) by striking out "for certain" the second place it appears; and

(4) by striking out "treatment" and inserting in lieu thereof "care or services".

(c) Section 663 is amended—

(1) in subsection (a)(1)—

(A) by striking out "may" and inserting in lieu thereof "shall, during fiscal years 1984 through 1988,";

(B) by inserting "otherwise being furnished care or services under this chapter" after "title";

(C) by striking out "and treatment" and inserting in lieu thereof "or services"; and

(D) by adding at the end the following new sentence: "In carrying out the pilot program under this subchapter, the Administrator may furnish such preventive health-care services to any other veteran described in section 612(f)(2) of this title.";

(2) by striking out subsection (b) and redesignating subsections (c) and (d) as subsections (b) and (c), respectively; and

(3) in subsection (c) (as so redesignated), by striking out "fiscal year 1984" and inserting in lieu thereof "each of fiscal years 1984 through 1988".

(d) Section 664 is amended by inserting "for each of fiscal years 1984 through 1988" after "Congress".

#### CHIROPRACTIC SERVICES

SEC. 105. (a)(1) Section 601 is amended by adding at the end the following new paragraph:

"(9) The term 'chiropractic services' means the manual manipulation of the spine performed by a chiropractor (who is licensed as such by the State in which he or she performs such services and who meets the uniform minimum standards promulgated for chiropractors under section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))) to correct a subluxation of the spine. For the purposes of this paragraph, such term does not include physical examinations, laboratory tests, radiologic

services, or other tests or services determined by the Administrator to be excluded."

(2) Subchapter III of chapter 17 is amended by adding at the end the following new section:

**"§ 630. Chiropractic services**

"(a) The Administrator shall, under regulations which the Administrator shall prescribe, reimburse a veteran eligible for medical services under this chapter for the reasonable charge for chiropractic services for which such veteran has made payment, or, in lieu of such reimbursement make payment of the reasonable charge for such chiropractic services directly to the chiropractor who furnished such services, if—

"(1) such chiropractic services were for the treatment of a service-connected neuromusculoskeletal condition of the spine,

"(2) the veteran is a veteran who has been furnished hospital care by the Veterans' Administration for a neuromusculoskeletal condition of the spine within a 12-month period prior to the provision of such chiropractic services, or

"(3) the veteran is a veteran described in section 612(f)(2) of this title who has been furnished hospital care or medical services by the Veterans' Administration for a neuromusculoskeletal condition of the spine, to the extent that such veteran is not entitled to such chiropractic services or reimbursement for the expenses of such services under an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement for the purpose of providing, paying for, or reimbursing expenses for such services.

"(b)(1) The Administrator shall, in consultation with appropriate public and non-profit private organizations and other Federal departments and agencies that provide reimbursement for chiropractic services, establish a schedule of reasonable charges for such services, which schedule shall be consistent with the reasonable charges allowed under title XVIII of the Social Security Act (42 U.S.C. ch. 7).

"(2) The amount payable by the Administrator for chiropractic services furnished under this section shall not exceed \$400 in any 12-month period in the case of any veteran.

"(c) Notwithstanding any other provision of this title, total expenditures for chiropractic services reimbursed under this section shall not exceed \$2,000,000 in any fiscal year and no reimbursement or payment may be made under this section for chiropractic services furnished after September 30, 1987."

(3) The table of sections at the beginning of chapter 17 of such title is amended by inserting after the item relating to section 629 the following new item:

**"630. Chiropractic services."**

(b) Not later than December 31, 1984, and not later than December 31 of each of the next 3 years thereafter, the Administrator of Veterans' Affairs shall prepare and submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the use made of the authority provided for in the amendments made by subsection (a) of this section. Each such report shall contain specification of—

(1) the number of requests by eligible veterans for reimbursement or payment for chiropractic services in the fiscal year preceding the fiscal year in which the report is submitted under section 630 of title 38, United States Code (as added by subsection (a)(1) of this section), and the number of such veterans who made such requests;

(2) the number of reimbursements or payments made by the Administrator of Veterans' Affairs under such section in such fiscal year and the number of veterans to or for whom such reimbursements or payments were made; and

(3) the total amounts of expenditures by the Administrator of Veterans' Affairs for such reimbursements and payments under such section in such fiscal year.

**COMMUNITY RESIDENTIAL CARE**

SEC. 106. (a) Subchapter III of chapter 17 is amended by adding at the end thereof the following new section:

**"§ 630A. Transfers for community residential care**

"(a) Subject to the terms and conditions set forth in this section and regulations prescribed by the Administrator under this section, the Administrator may assist a veteran to whom the Administrator is furnishing hospital, domiciliary, or nursing



home care or medical services on an outpatient basis or has furnished such care or services within the preceding 12 months and for whom placement in a community residential-care facility is appropriate by referring such veteran for and aiding such veteran in obtaining placement in such a facility.

"(b)(1) The Administrator may not provide assistance under subsection (a) of this section with respect to a community residential-care facility unless the Administrator has approved such facility in accordance with paragraph (2) of this subsection.

"(2) The Administrator's approval of such a facility under paragraph (1) of this subsection shall be based upon the Administrator's determination, after inspection of such facility, that such facility meets the standards set forth in the regulations prescribed under this section. Such standards shall include:

"(A) health and safety criteria, including a requirement of compliance with applicable State laws and local ordinances relating to health and safety;

"(B) a requirement that the costs charged for care by a community residential-care facility be reasonable, as determined by the Administrator, giving consideration to such factors as (i) the level of care, supervision, and other services to be provided, (ii) the cost of goods and services in the geographical area in which the facility is located, and (iii) comparability with other facilities in such area providing similar services;

"(C) criteria for determining the resources that a community residential-care facility needs in order to provide an appropriate level of services to veterans; and

"(D) such other criteria as the Administrator determines are appropriate to protect the welfare of veterans placed in community residential-care facilities under this section.

"(3) Payment of the charges for any care or services provided to a veteran whom the Administrator has referred to a community residential-care facility under this section shall not be the responsibility of the United States Government or the Veterans' Administration.

"(c)(1) The Administrator shall provide for periodic inspection of community residential-care facilities to determine continued compliance with the standards set forth in regulations prescribed under this section. Such standards and any report of inspection of such facilities under subsection (b)(2) of this section or under this subsection made by or for the Administrator shall, to the extent possible, be made available to all Federal, State, and local agencies charged with the responsibility of licensing or otherwise regulating or inspecting such facilities.

"(2) If the Administrator determines that such a facility is not in compliance with such standards, the Administrator, in accordance with regulations prescribed under this section—

"(A) shall cease to refer veterans to such facility; and

"(B) may, with the permission of the veteran or the person or entity authorized by law to give permission on behalf of the veteran, assist in removing a veteran from such facility.

Regulations prescribed to carry out this paragraph shall provide for reasonable notice and, upon request made on behalf of such facility, a hearing before any action authorized by this paragraph is taken.

"(d) The Administrator shall prescribe regulations to carry out this section.

"(e) For the purpose of this section, the term 'community residential-care facility' means a residential facility that provides, at a minimum, room and board and such limited personal care for and supervision of residents as the Administrator determines, in accordance with regulations prescribed under this section, are necessary for such resident's health, safety, and welfare."

(b) The table of sections at the beginning of chapter 17 is amended by adding after the item relating to section 630 the following new item:

"630A. Transfers for community residential care."

#### STATE HOME PER DIEM INCREASE

SEC. 107. (a) Section 641(a) is amended by striking out "\$6.35", "\$12.10", and "\$13.25" and inserting in lieu thereof "\$7.30", "\$13.95", and "\$15.25", respectively.

(b)(1) Except as provided in paragraph (2), the amendments made by subsection (a) shall take effect on April 1, 1984.

(2) With respect to months prior to September 1984, such amendments shall take effect only if adequate funds are specifically provided for such purpose in an appropriations Act.

## PUERTO RICO

SEC. 108. (a) Section 601(4)(C)(v) is amended by striking out "September 30, 1983" and inserting in lieu thereof "September 30, 1984".

(b) Not later than December 1, 1983, the Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing the plans of the Administrator, and the reasons therefor, for meeting the health-care needs of veterans (as defined in section 101(2) of title 38, United States Code) in the Commonwealth of Puerto Rico and in the Virgin Islands who are eligible for health care under chapter 17 of title 38, United States Code, and, most particularly, the health-care needs of veterans (as so defined) in that population whose disabilities are service-connected (as defined in section 101(16) of such title). Such report shall (1) take into account the report by the Veterans' Administration's Office of Inspector General entitled "Report of Special Audit, Veterans' Administration Medical and Regional Office Center, San Juan, Puerto Rico (Report No. 3R2-A05-043)", dated February 22, 1983, and (2) include, with respect to each construction project (if any) that the Administrator recommends in such plans and for which a prospectus would be required under section 5004(b) of such title if such project were proposed to the Congress by the President or the Administrator, a prospectus that meets the requirements of such section.

## RESOURCE REALIGNMENT

SEC. 109. (a) Section 111(e) is amended by adding at the end the following new paragraph:

"(5)(A) In order to achieve compliance with the limitation in subsection (b) of section 109 of the Veterans' Health Care and Programs Improvement Act of 1983 on certain obligations under this section in fiscal year 1984, the Administrator is hereby authorized to and shall prescribe regulations to be effective on October 1, 1983, restricting, to the extent necessary to achieve such compliance, the making of payments under this section to persons other than persons receiving benefits under this title for or in connection with a service-connected disability.

"(B) The substantive provisions so restricting such payments may be continued in effect in regulations after the end of such fiscal year."

(b) Notwithstanding any other provision of law and subject to subsection (e), not more than \$71,209,000 may be obligated in fiscal year 1984 from the Veterans' Administration medical care account (hereinafter in this section referred to as "the account") for payments under section 111 of title 38, United States Code.

(c)(1) Of the funds that are appropriated to the account for fiscal year 1984, the Administrator shall direct that a total of not less than \$20,000,000 shall be made available for obligation in fiscal year 1984 for—

(A) the provision of nursing home care and adult day health care to eligible veterans under section 620 of title 38, United States Code (as amended by section 101 of this Act), and

(B) the provision of preventive health-care services (as defined in section 662 of such title) under sections 610 and 612 and subchapter VII of chapter 17 of such title (as amended by section 104 of this Act),

over and above the amount that was requested to be appropriated for such care and services in the President's budget transmitted pursuant to section 1105(a) of title 31, United States Code (hereinafter in this section referred to as "the President's budget"), for fiscal year 1984. In so directing, the Administrator shall allocate such total of not less than \$20,000,000 so as to make available for such care or services under each such section and under such subchapter a significant portion of such total.

(2) If at any time during fiscal year 1984 the Administrator estimates that obligations in such year from the account for payments under section 111 of title 38, United States Code, will be an amount less than \$71,209,000, the Administrator shall direct that such amount be obligated, as specified by the Administrator, for care described in clause (A) of paragraph (1), services described in clause (B) of paragraph (1), or otherwise authorized activities that are conducted by facilities over which the Administrator has direct jurisdiction and that are designed to avoid the need for, or to shorten the periods of, the institutionalization of veterans, or a combination of such care, services, and activities.

(3) Not later than September 15, 1983, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate (hereinafter in this section referred to as "the Committees") a report containing information specifying—

(A) the total amount that the Administrator estimates will be obligated in fiscal year 1984 from the account for such payments (taking into account the effect of the regulations described in paragraph (5)(A) of section 111(e) of such title (as added by subsection (a)));

(B) the amounts requested in the President's budget for fiscal year 1984 to be appropriated for the care and services specified in paragraph (1) under each section and subchapter there specified; and

(C) the amounts of the portion of the total, over and above amounts so requested to be appropriated, that the Administrator has directed be made available for obligation for such care and services under each such section and subchapter and the justification for each such amount.

(4) On the same day that the President's budget for fiscal year 1985 is transmitted, the Administrator shall submit to the Committees a report containing information (A) with respect to each month of fiscal year 1984, as to the amounts of the portion of such total that have been or are estimated to be obligated for such care and services obligated under each such section and subchapter, and (B) specifying (i) any revisions that the Administrator has made, since submitting the report required by paragraph (3), in the amounts of the portions of such total that the Administrator has directed to be made available for obligation under each such section and subchapter, and (ii) the justification for any such revisions.

(d)(1) Not later than August 1, 1984, the Administrator shall submit to the Committees and to the Comptroller General of the United States a report containing, with respect to each category of care and services described in subsection (c)(1)—

(A)(i) information, for each month of fiscal year 1984 for which such information is then available, as to the amounts obligated and the amounts by which such obligations have exceeded one-twelfth of the amounts requested to be appropriated in the President's budget for fiscal year 1984, and (ii) taking into account the information provided pursuant to subclause (i), the amounts that the Administrator estimates have been or will be obligated in each remaining month of fiscal year 1984 and the amounts by which such estimated amounts will exceed such one-twelfth; and

(B) the justification for the Administrator's estimates of the amounts that will be obligated in each such category in fiscal year 1984.

(2) Not later than September 1, 1984, the Comptroller General shall submit to the Committees a report containing—

(A) the results of an analysis by the Comptroller General, conducted in consultation with the Director of the Congressional Budget Office, of the report required by paragraph (1); and

(B) the Comptroller General's determination whether, on the basis of such analysis, the total obligations for care and services described in subsection (c)(1) in fiscal year 1984 can reasonably be expected to exceed by a total of \$20,000,000 or more the amount requested to be appropriated for such care and services in the President's budget for fiscal year 1984.

(3) If the Comptroller General's determination under paragraph (2) is that the amount by which such total obligations will exceed the amount so requested to be appropriated for such care and services in fiscal year 1984 cannot reasonably be expected to be \$20,000,000 or more, subparagraph (B) of section 111(e)(5) of title 38, United States Code (as added by subsection (a)), shall lose effect on September 30, 1984, as if repealed by an Act of Congress.

(e)(1) If the Comptroller General of the United States determines, pursuant to paragraph (2), that the enactment of any law or any action of the Director of the Office of Management and Budget in connection therewith has made it impossible for the Administrator, based on the annual rate of appropriations that have been made to the account for fiscal year 1984 as of the date of such enactment, to comply with the provisions of subsection (c)(1) without causing to be diverted funds that have been appropriated to the account and intended by the Congress to be obligated for a purpose other than payments under section 111 of title 38, United States Code, then on the forty-sixth day after the date of the enactment of such law, the amendment made by subsection (a) and the provisions of subsection (b) shall lose effect as if repealed by an Act of Congress.

(2) Not later than 45 days after the enactment of each law making appropriations to the account for fiscal year 1984 or in any way restricting the obligation or expenditure of any funds appropriated to the account for fiscal year 1984, the Comptroller General, after consulting with the Administrator, shall submit to the Committees a report containing the Comptroller General's determination whether such law of such action so makes such compliance impossible.

(f) Not later than the date on which the President's budget for fiscal year 1986 is transmitted, the Administrator shall submit to the Committees a report containing (1) information as to the amounts actually obligated in fiscal year 1984 (A) from the account for payments under section 111 of title 38, United States Code, (B) for each category of care and services described in subsection (c)(1), and (C) any additional amounts obligated pursuant to subsection (c)(2) and the purposes for which they were spent; and (2) an explanation of the reasons for any significant differences between such actual obligations and the amounts of such expenditures during such fiscal year as estimated pursuant to subsection (d)(1).

## TITLE II—PROVISIONS TO IMPROVE THE RECRUITMENT AND RETENTION OF CERTAIN PERSONNEL

SEC. 201. Section 4104 is amended—

(1) in paragraph (2), by striking out "physical therapists,";

(2) in paragraph (2), by striking out "bacteriologists" and inserting in lieu thereof "microbiologists";

(3) by striking out the period at the end of paragraph (2) and inserting in lieu thereof a semicolon; and

(4) by adding at the end the following new paragraph:

"(3) Certified or registered respiratory therapists, licensed physical therapists, and licensed practical or vocational nurses."

SEC. 202. (a) Section 4105(a) is amended—

(1) in clause (1), by striking out "Physicians" and inserting in lieu thereof "Physician";

(2) by striking out clauses (8) and (9);

(3) by redesignating clause (10) as clause (8); and

(4) by adding at the end the following new clause:

"(9) Physician assistant, expanded-function dental auxiliary, certified or registered respiratory therapist, licensed physical therapist, licensed practical or vocational nurse, occupational therapist, dietitian, microbiologist, chemist, biostatistician, medical technologist, dental technologist, or other position—

"have such medical, dental, scientific, or technical qualifications as the Administrator shall prescribe."

(b) Section 4105(b) is amended by striking out all beginning with "as physician" through "auxiliary" and inserting in lieu thereof "to a position listed in section 4104(1) of this title".

SEC. 203. (a) Section 4106 is amended by adding at the end the following new subsection:

"(g)(1) The Administrator, upon the recommendation of the Chief Medical Director, may use (A) the authority in subsection (a) of this section to establish the qualifications for and, subject to paragraph (2) of this subsection, to appoint individuals to positions listed in section 4104(3), and (B) the authority in subsection (c) of this section for the promotion and advancement of Veterans' Administration employees serving in such positions.

"(2) In using such authority to appoint individuals to such positions, the Administrator shall apply the principles of preference for the hiring of veterans and other persons established in subchapter I of chapter 33 of title 5, United States Code."

(b)(1) Not later than 90 days after the enactment of this section, the Administrator of Veterans' Affairs shall publish in the Federal Register, for public review and comment for a period of not less than 30 days, proposed regulations for the continued implementation of paragraph (2) of subsection (g) of section 4106 of title 38, United States Code (as added by subsection (a)).

(2) Not later than 180 days after the date of the enactment of this section, the Administrator shall publish in the Federal Register final regulations for such implementation.

SEC. 204. Section 4107 is amended—

(1) in subsection (f)—

(A) by striking out the comma after "regulations" and inserting in lieu thereof "(1)"; and

(B) by inserting before the period a comma and "and (2) notwithstanding any other provision of law, when the Administrator determines it to be necessary in order to obtain or retain the services of certified or registered respiratory therapists, licensed physical therapists, or licensed practical or vocational nurses, the Administrator may, on a nationwide, local, or other geographic basis, pay persons employed in such positions additional pay on the same basis as provided for nurses in subsection (e) of this section"; and



(2) by amending subsection (g)—

(A) by amending clause (A) of paragraph (1) to read as follows:

“(A) of individuals employed in positions listed in paragraphs (1) and (3) of section 4104 of this title; or”

(B) by amending paragraph (3) by inserting “and licensed physical therapists” after “anesthetists”; and

(C) by amending paragraph (4) by inserting “with respect to health-care personnel described in clause (B) of such paragraph” after “subsection”.

SEC. 205. The second sentence of section 4110(a) is amended to read as follows: “The majority of employees on a disciplinary board shall be employed in the same category of position as the employee who is the subject of the charges.”

SEC. 206. Section 4111 is amended—

(1) by inserting “(a)” before “There”;

(2) in subsection (a) (as so designated by clause (1)), by striking out “paragraph (1)” and inserting in lieu thereof “paragraphs (1) and (3)”; and

(3) by adding at the end the following new subsection:

“(b) Notwithstanding any other provision of law, the Administrator may, after considering an individual's existing pay, higher or unique qualifications, or the special needs of the Veterans' Administration, appoint an individual to a position in the Department of Medicine and Surgery providing direct patient-care services or services incident to direct patient-services at a rate above the minimum rate of the appropriate grade.”

SEC. 207. (a)(1) Not later than January 1, 1984, the Administrator of Veterans' Affairs and the Director of the Office of Personnel Management shall submit a joint report to the Committees on Veterans' Affairs of the House of Representatives and the Senate (hereinafter in this section referred to as “the Committees”) regarding the status of efforts to carry out the recommendations made in the report prepared by the Veterans' Administration, pursuant to section 117 of Public Law 96-330, entitled “Study of the Feasibility and Desirability of Converting Selected Health Care Occupations to Title 38, United States Code” and transmitted to the Committees on September 1, 1982.

(2) Such report shall contain—

(A) with respect to each such recommendation, information on the decision that has been made as to whether such recommendation is being implemented in the manner described in the report and, if not, as to whether it is to be implemented in a modified form or not implemented and a statement of the reasons for such decision, and of the position of each agency with respect to such recommendation and such decision;

(B) the timetable for the actions planned for the implementation of each recommendation that is being implemented either in its original form or as modified;

(C) any further recommendations of the Administrator or Director or both for legislative or administrative action, or both, relating to the subject matter of such report; and

(D) such other information relating to the subject matter of such report as the Administrator or the Director or both consider appropriate.

(b)(1) Not later than 90 days after the date of the enactment of this Act, the Administrator shall submit to the Committees a report on the implementation of the amendments made by this title, including the steps taken and planned to be taken (including the timetable therefor and the justification therefor, to exercise the authorities provided by such amendments. Such report shall also contain a description and justification of the extent to which such authorities have not been or are not planned to be exercised.

(2) Not later than September 30, 1985, the Administrator shall submit to the Committees a report containing—

(A) descriptions of (i) the results of the exercise of the authorities provided in the amendments made by this title, and (ii) the efforts under section 4101(b) of title 38, United States Code, to develop and carry out programs of education and training for career advancement for nursing assistants, noncertified, non-registered inhalation therapists, and other para-professionals employed in the Department of Medicine and Surgery who provide either direct patient-care services or services incident to direct patient-care services;

(B) an evaluation of the effects of both the exercise of such authorities and such programs on the recruitment and retention of Veterans' Administration employees, on such employees' productivity and morale, and on such employees' effectiveness in carrying out the missions of the Veterans' Administration; and

(C) such recommendations for administrative or legislative action, or both, as the Administrator considers appropriate in light of such evaluation.

### TITLE III—WOMEN VETERANS

#### ADVISORY COMMITTEE ON WOMEN VETERANS

SEC. 301. (a) Chapter 3 is amended by inserting after section 221 the following new section:

##### "§ 222. Advisory Committee on Women Veterans

"(a)(1) The Administrator shall establish an advisory committee to be known as the Advisory Committee on Women Veterans (hereinafter in this section referred to as 'the Committee').

"(2) The members of the Committee shall be appointed by the Administrator from the general public and shall include—

"(A) appropriate representatives of women veterans;

"(B) individuals who are recognized authorities in fields pertinent to the needs of women veterans, including the gender-specific health-care needs of women; and

"(C) appropriate representatives of both female and male service-connected-disabled veterans, including at least one female service-connected disabled veteran and at least one male service-connected disabled veteran.

The Committee shall also include, as ex officio members, the Chief Medical Director and the Chief Benefits Director, or their designees, and one public member and one military member of the Department of Defense Advisory Committee on Women in the Services selected therefrom by the Administrator after consultation with the Secretary of Defense. The Administrator may also invite representatives of such other departments and agencies of the United States as the Administrator considers appropriate to participate in the meetings and other activities of the Committee.

"(3) The Administrator shall determine the number, terms of service, and pay and allowances of members of the Committee appointed by the Administrator, except that a term of service of any such member may not exceed 3 years. The Administrator may reappoint any such member for such additional terms of service as the Administrator considers appropriate.

"(4) The Committee shall meet not less than three times in fiscal year 1984 and thereafter at such times as determined by the Committee but not less than two times in each fiscal year.

"(b) The Administrator shall, on a regular basis, consult with and seek the advice of the Committee with respect to (1) the administration of benefits under this title for women veterans, (2) reports and studies pertaining to women veterans, and (3) the needs of such veterans with respect to compensation, health care, rehabilitation, outreach, and other benefits and programs administered by the Veterans' Administration.

"(c) Not later than July 1, 1984, and not later than July 1 of each year thereafter, the Committee shall submit to the Administrator a report on the programs and activities of the Veterans' Administration that pertain to women veterans. Each such report shall contain (1) an assessment of the needs of such veterans with respect to compensation, health care, rehabilitation, outreach, and other benefits and programs administered by the Veterans' Administration, (2) a review of the programs and activities of the Veterans' Administration designed to meet such needs, and (3) such recommendations (including recommendations for administrative and legislative action) as the Committee considers appropriate. Within 30 days after receiving each such report, the Administrator shall submit it to the Congress with any comments concerning the report that the Administrator considers appropriate. The Committee may also submit to the Administrator such other reports and recommendations as the Committee considers appropriate. The Administrator shall submit with each annual report submitted to the Congress pursuant to section 214 of this title a summary of all reports and recommendations of the Committee submitted to the Administrator since the previous annual report of the Administrator submitted to the Congress pursuant to such section."

(b) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 221 the following new item:

"222. Advisory Committee on Women Veterans."

#### FEE-BASIS CARE FOR WOMEN VETERANS

SEC. 302. (a) Section 601(4)(C)(iv) is amended by inserting after "veterans" a comma and "and, until September 30, 1989, medical services described in section 612(f)(1)(A) of this title for a woman veteran if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that a disability of such woman veteran relating to her gender precludes appropriate treatment in facilities described in clause (A) or (B) of this paragraph".

(b)(1) At the time the President's budget for each of fiscal years 1985 through 1989 is transmitted to Congress pursuant to section 1105(a) of title 31, United States Code, the Administrator of Veterans' Affairs shall (as part of the documentation submitted by the Administrator in justification of such budget with respect to the Veterans' Administration medical care account) report to the appropriate committees of the Congress on (A) the Administrator's plans for, and estimated extent of, utilization in such fiscal year, of (including estimated amounts of expenditures under) the authority provided by the amendment made by subsection (a) and (B) the activities undertaken and planned with respect to the utilization of (including estimated amounts of expenditures under) such authority in the fiscal year during which such budget is submitted. In so reporting with respect to fiscal years 1986 through 1989, the Administrator shall also provide information on activities undertaken (including amounts of expenditures) under such authority during the year or years preceding the fiscal year in which the report is submitted.

(2) Not later than September 30, 1988, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing (A) the Administrator's recommendations, and reasons therefor, with respect to whether the September 30, 1989, expiration date in such authority should be extended and, if so, the date to which such authority should be extended, or whether such authority should be made permanent, and (B) any other recommendations for legislative or administrative action that the Administrator considers appropriate with respect to the Veterans' Administration's meeting the gender-related health-care needs of women veterans. Prior to submitting such report to such Committees, the Administrator shall submit the proposed report to the Advisory Committee on Women Veterans, established pursuant to the amendments made by section 301(a) of this Act, and shall consult with the Advisory Committee which shall promptly advise the Administrator of its views on the Administrator's proposed report and its recommendations on the subjects covered therein, and the Administrator shall include such views in such report along with any comments the Administrator considers appropriate.

#### TITLE IV—PRESUMPTION CONCERNING DYSTHYMIC DISORDER

SEC. 401. Section 312(b) is amended—

- (1) in clause (8), by striking out "or";
- (2) in clause (9), by inserting after the comma "or"; and
- (3) by adding at the end the following new clause:

"(10) dysthymic disorder (or depressive neurosis)."

#### TITLE V—STATUS AND ROLE OF ADMINISTRATOR OF VETERANS' AFFAIRS

SEC. 501. (a) The Congress finds that—

- (1) the Nation has an historic and deeply-rooted commitment to providing benefits and services to those who served in the Armed Forces;
- (2) this commitment must be continued and maintained, both to fulfill moral obligations to those who served in the past and to assure those now in the Armed Forces and potential service men and women that the Nation's obligations to those who serve will always be honored;
- (3) the Veterans' Administration is the principal Federal entity responsible for veterans' benefits and programs;
- (4) the Veterans' Administration has a potential population of beneficiaries totaling nearly thirty million veterans and over sixty-six million survivors and dependents;
- (5) the Veterans' Administration will distribute over \$13 billion in income maintenance payments and approximately \$1.7 billion in education, training, and rehabilitation assistance payments in fiscal year 1983; operates one of the

Federal Government's two major home loan guaranty programs, with over 4 million loans currently guaranteed; administers the largest direct insurance program in the Nation; operates 108 national cemeteries and provides burial assistance for nearly 350,000 deceased veterans annually;

(6) the Veterans' Administration operates the largest centrally administered health-care system—consisting of, among other facilities, 172 hospitals, 226 outpatient clinics, and 99 nursing home care units—in the United States;

(7) the Veterans' Administration health-care system serves as the primary backup to the medical resources of the Department of Defense in time of war or national emergency involving the use of the Armed Forces in armed conflict;

(8) in terms of share of the annual Federal budget, the Veterans' Administration ranks sixth among Federal departments and agencies, and among Federal departments and agencies only the Department of Defense employs more personnel;

(9) the Administrator of Veterans' Affairs is the principal executive branch official responsible for the administration of the benefits, services, and programs of the Veterans' Administration and for seeking the coordination of veterans' programs administered by other Federal departments and agencies;

(10) there is a need for greater coordination between the Veterans' Administration and other Federal entities administering veterans programs and between the Veterans' Administration and other Federal entities providing similar benefits to individuals on a basis other than their status as veterans;

(11) by virtue of the Administrator of Veterans' Affairs not being included in the President's Cabinet, the Administrator generally is not included in Cabinet meetings and deliberations and generally does not have the ready access to the President and senior advisers on the President's staff that Cabinet members have; and

(12) as a consequence, Presidential decisions affecting veterans and the Veterans' Administration are made from time to time without an understanding of their full impact on veterans and on the Veterans' Administration's performance of its statutory missions.

(b) In view of the findings in subsection (a), it is the sense of the Congress that the Administrator of Veterans' Affairs should be designated by the President as a member of, and full participant in all activities of, the Cabinet and as the President's principal adviser on all matters relating to veterans and their dependents.

#### TITLE VI—RADIATION EXPOSURE STUDY AND GUIDE

SEC. 601. (a)(1)(A) Subject to paragraph (2)(B), the Administrator of Veterans' Affairs, through contracts or agreements with private or public agencies or persons (other than the Department of Defense or the Department of Energy) and in consultation with the Director of the Office of Technology Assessment, shall provide for the conduct of an epidemiological study of the long-term adverse health (including psychological) effects of exposure to ionizing radiation from the detonation of a nuclear device in connection with the test of such device or with the American occupation of Hiroshima and Nagasaki, Japan, during the period beginning September 11, 1945, and ending on July 1, 1946, in persons who, while serving in the Armed Forces of the United States, may have been exposed to such radiation. Such study shall include, but not necessarily be limited to, a study of identifiable prevalent illnesses, including malignancies, in the persons potentially exposed and genetic and congenital problems suffered by the natural children of such persons.

(B) In the event that the Administrator determines that it is not feasible to conduct a scientifically valid study of any or all of the matters required under subparagraph (A) to be studied, the Administrator shall promptly notify the appropriate committees of the Congress of this determination and the reasons therefor.

(2)(A) The Director of the Office of Technology Assessment shall monitor the development of the protocol or protocols for and the conduct of study under paragraph (1)(A) and shall submit to the appropriate committees of Congress, at each of the times specified in the second and third sentences of this subparagraph, a report on such monitoring. Reports under the preceding sentence shall be submitted within 6 months after the date of the enactment of this Act, within 12 months after such date, within 25 months after such date, and annually thereafter until such study is completed, and shall contain a review of and comments on, the most recent report of the Administrator required to be submitted under paragraph (5). In the event that the protocol for such study or any part thereof is not completed by the end of the 12-month period beginning on the date of the enactment of this Act, the Director shall submit to such committees, at the end of the 60-day period beginning at



the end of such 12-month period and thereafter at the end of each succeeding 60-day period until such protocol is completed, a report on the status of such protocol.

(B) In the event that the Administrator notifies the Congress of a determination or determinations made pursuant to paragraph (1)(B), the Director, not later than 60 days after such notification, shall submit to the appropriate committees of the Congress a report evaluating and commenting on such determination and the reasons therefor. To the extent that the Director concurs in such determination or determinations of the Administrator, the matter or matters required under paragraph (1)(A) to be studied to which such determination or determinations apply shall, notwithstanding paragraph (1)(A), not be required to be studied. In the event that the Administrator has determined under paragraph (1)(B) that, taken as a whole, study under paragraph (1)(A) is not scientifically feasible and the Director concurs in the Administrator's determination, the requirement in paragraph (1)(A) that the Administrator provide for the conduct of epidemiological study shall lose effect as if repealed by an Act of Congress.

(3) Not later than 12 months after the date of the enactment of this Act, the Administrator shall submit to the appropriate committees of the Congress a report on the development of a protocol or protocols for study under paragraph (1)(A) and, in the event that such a protocol has not been developed, an estimate of the completion date therefor together with an estimate of the cost to be incurred in developing such protocol.

(4) At such time as the Administrator has entered into a contract or agreement with an agency or person for the conduct of a study under paragraph (1)(A), the Administrator and such agency or person shall submit a joint report to the appropriate committees of the Congress containing detailed information on the proposed study, including estimates of the number of individuals to be studied, the length of the study (specifying significant milestones prior to its completion), and the total cost of the study.

(5) Not later than 24 months after the date of the enactment of this Act, and annually thereafter, the Administrator shall submit to the appropriate committees of the Congress a report on the status of study under paragraph (1)(A). Such report shall contain (A) a description of the progress on and any results obtained under such study, and (B) such comments and recommendations for administrative or legislative action, or both, as the Administrator considers appropriate in light of such progress and results.

(6) Not later than 90 days after the submission of each report required by paragraph (5), the Administrator, based on the progress and results described in such report and the comments and recommendations thereon and any other available pertinent information, shall publish in the Federal Register, for public review and comment, a description of actions, if any, that the Administrator proposes to take with respect to programs administered by the Veterans' Administration. Each such description shall include a justification for any such action the Administrator proposes to take.

(7) The requirement in paragraph (5) for the submission of annual reports shall expire upon the submission of a report after the completion of study under paragraph (1)(A).

(b)(1) Not later than one year after the date of the enactment of this Act, the Administrator shall develop and publish an indexed reference guide, derived from existing pertinent research-result compilations, designed to provide appropriate Veterans' Administration personnel who either furnish health care or adjudicate claims for benefits under title 38, United States Code, with readily useable information regarding the state of medical and other scientific information on any long-term adverse health (including genetic and psychological) effects in humans of exposure to radiation, including nuclear-device, medical, and occupational exposures.

(2) Not later than 13 months after the date of the enactment of this Act, the Administrator shall submit to the appropriate committees of the Congress a report on the indexed reference guide developed under paragraph (1), together with such comments and recommendations for administrative or legislative action, or both, as the Administrator considers appropriate, including recommendations regarding (A) the need for any additional research that the Administrator considers necessary for the resolution of questions regarding adverse long-term health effects result from exposure to radiation, and (B) the departments, agencies, or instrumentalities that should carry out such research.

(3) The Administrator shall distribute (A) such guide to the Veterans' Administration personnel described in paragraph (1), and (B) such guide and such report to the departments, agencies, and instrumentalities described in subsection (c) and such other departments, agencies, and instrumentalities of the Federal Government as

the Administrator considers appropriate and shall recommend to the appropriate such departments, agencies, and instrumentalities that they carry out any such additional research.

(4) The Administrator shall periodically review such guide and, to the extent the Administrator considers appropriate, update it based on the results of research completed after the guide was published or other available pertinent information.

(c)(1) For the purpose of ensuring that any study, research, or other activity carried out by the Federal Government with respect to adverse health effects in humans from exposure to radiation is scientifically valid and is conducted with efficiency and objectivity, the President shall ensure that—

(A) study under subsection (a)(1)(A), the development of the guide required by subsection (b)(1), and such additional research as may be identified pursuant to subsection (b)(2) are fully coordinated with studies or other activities which are planned, are being conducted, or have been completed by other departments, agencies, and instrumentalities of the Federal Government and which pertain to the adverse health effects in humans from exposure to radiation, including the radioepidemiological tables mandated by section 7 of the Orphan Drug Act (Public Law 97-414; 96 Stat. 2059); and

(B) all appropriate coordination and consultation is accomplished between and among the Administrator and the heads of such departments, agencies, and instrumentalities that may be engaged, during the conduct of study under subsection (a)(1)(A), in the design, conduct, monitoring, or evaluation of such radiation-exposure studies.

(2) Not later than 90 days after the date of the enactment of this Act, the President shall submit to the appropriate committees of the Congress a report containing a description of the steps taken and plans made to ensure the coordination and consultation required by paragraph (1).

(d)(1) There are authorized to be appropriated for fiscal years after fiscal year 1983 such sums as may be necessary for the conduct of the study required by subsection (a)(1)(A).

(2) The authority to enter into contracts under subsection (a)(1)(A) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriations Acts.

## TITLE VII—MISCELLANEOUS AND TECHNICAL AMENDMENTS

SEC. 701. Clause (3) of section 610(a) is amended by inserting "(A)" after "(3)" and by inserting at the end "or (B) a person who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such person's continuing eligibility for such care is provided for in the judgment or settlement described in such section;"

SEC. 702. (a) Section 203(b) is amended by striking out "not".

(b) Section 360 is amended by striking out "has suffered (1)" and inserting in lieu thereof "(1) has suffered".

(c) Section 361 is amended by striking out "United States Code,".

(d) Section 719(b) is amended by striking out "subsections" and inserting in lieu thereof "sections".

(e) Section 1682(c)(1)(C) is amended by inserting a comma after "week".

(f) Sections 2002 and 2002A are amended by striking out "a Assistant" and inserting in lieu thereof "an Assistant".

(g) Section 3005 is amended by striking "subchapter II of chapter 7 of title 42" each place it appears and inserting in lieu thereof "title II of the Social Security Act".

(h) Section 4118(g)(3) is amended by striking out the comma after "title 31".

(i) Section 4142 is amended—

(1) in subsection (f)(2), by striking out "section 3324(a) and (b)" and inserting in lieu thereof "subsections (a) and (b) of section 3324"; and

(2) in subsection (i)(4), by striking out the comma after "not accepted".

(j) Section 5010(c)(2)(B) is amended by striking out "or" the first place it appears and inserting in lieu thereof "and".

Amend the title so as to read:

A bill to amend title 38, United States Code, to provide for adult day health care services for veterans, to establish a Veterans' Administration Advisory Committee on Women Veterans, to promote the recruitment and retention of certain health-care personnel in the Department of Medicine and Surgery of the Veterans' Admin-

istration; to extend the period for Vietnam-era veterans to request counseling under the readjustment counseling program to establish a presumption of service-connection for former prisoners of war suffering from dysthymic disorder, to express the sense of the Congress with respect to the role of the Administrator of Veterans' Affairs, to require the Administrator of Veterans' Affairs to conduct an epidemiological study and develop a reference guide to long-term health effects in veterans of exposure to ionizing radiation; and for other purposes.

### INTRODUCTION

S. 578 was introduced on February 23, 1983, by the Chairman of the Committee, Senator Alan Simpson. As introduced, S. 578 would have, first, provided for adult day health-care services for veterans; second, authorized the VA to administer a community residential-care program; third, established a presumption of service connection for former prisoners of war suffering from dysthymic disorder; and fourth, revised eligibility for reimbursement of expenses of travel for VA health care.

On January 26, 1983, Senator Alan Cranston, the Committee's Ranking Minority Member, together with Committee members Senators Randolph, Matsunaga, DeConcini, and Mitchell, introduced S. 11. As introduced, S. 11 would have, first, established a VA Advisory Committee on Women Veterans; second, required and authorized certain preventive health-care activities; third, authorized the Administrator to provide certain outpatient care on a fee-for-service basis for a non-service-connected gender-related disability of a woman veteran; fourth, extended the period for Vietnam-era veterans to request counseling under the VA's Readjustment Counseling Program; fifth, enhanced the VA's ability to recruit and retain certain health-care personnel in its Department of Medicine and Surgery; sixth, expressed the sense of the Congress with respect to the role of the Administrator of Veterans' Affairs; and seventh, required the Administrator to provide for the conduct of an epidemiological study of long-term health effects in veterans from exposure to ionizing radiation from nuclear test detonations and of a review and analysis of the literature relating to long-term adverse health effects from exposure to radiation.

On February 23, 1983, Senator Strom Thurmond introduced S. 567. As introduced, S. 567 would have authorized reimbursement for the reasonable charges for chiropractic services provided to certain veterans.

On March 1, 1983, Senator Cranston, with Senator Randolph's cosponsorship, introduced S. 629. As introduced, S. 629 would have increased the per diem rate payable by the VA to States providing domiciliary, nursing home, and hospital care to eligible veterans in State veterans' homes.

On March 3, 1983, Senator Alan Simpson introduced S. 664 at the request of the Administration. As introduced, S. 664 would have extended for three years the authority of the Administrator of Veterans' Affairs to provide certain contract hospital care and medical services in Puerto Rico, the Virgin Islands, and other territories.

On January 26, 1983, Senator Cranston, with the cosponsorship of Committee members Randolph, Matsunaga, DeConcini, Mitchell,



Denton, and Murkowski, introduced S. Con. Res. 2. As introduced S. Con. Res. 2 expressed the sense of the Congress that the Administrator of Veterans' Affairs should be designated a member of the President's Cabinet.

On March 9 and 10, 1983, the Committee held hearings, chaired by Senator Simpson, to receive testimony on S. 578, S. 11, S. 567, S. 629, S. 664, and S. Con. Res. 2. Testimony was received on March 9 from Dr. Donald Custis, Chief Medical Director of the VA; James Morrison, Jr., Associate Director for the Compensation Group of the Office of Personnel Management; William Weissert, Ph. D., Senior Research Associate at the Urban Institute; Dr. Stanley Kortenman, Chief of Medical Service at the VA Medical Center in Sepulveda, California; Sudie Goldston, Chair, the National Institute on Adult Daycare of the National Council on Aging; Glenn Gee, President of the American Association for Respiratory Therapy; R. Charles Harker, Director of Government Relations of the American Physical Therapy Association; and Paul Tendler, representing the National Federation of Licensed Practical Nurses.

On March 10 testimony was received from the Honorable Baltasar Corrada, the Resident Commissioner of Puerto Rico; Clyde Behney, Program Manager for Health of the Office of Technology Assessment; Dr. Nora Scott Kinzer, Special Assistant to the Administrator of Veterans' Affairs; representatives of the American Veterans Committee; the Vietnam Veterans of America; the American Legion, the Veterans of Foreign Wars, the Disabled American Veterans, and AMVETS; Robert Fitzgerald, International Chiropractors Association; and Lee Selby, American Chiropractors Association.

After carefully reviewing the testimony, the Committee met in open session on April 20, 1983, and voted unanimously to report favorably S. 578 with an amendment in the nature of a Committee substitute. S. 578, as reported, consists of provisions derived with modifications from S. 578, S. 11, S. 567, S. 629, S. 664, and S. Con. Res. 2.

#### SUMMARY OF S. 578 AS REPORTED

##### *Basic Purpose*

The basic purpose of S. 578 as reported (hereinafter referred to as "the Committee bill") is to maintain and improve the quality, scope, and efficiency of health-care services provided the Nation's veterans through the Veterans' Administration's health-care system.

The Committee bill would accomplish this purpose, first by enhancing the VA's capability to provide appropriate and cost-effective alternatives to expensive institutional medical care by providing the Administrator with the authority to conduct a pilot program of adult day health-care services, clarifying the authority to administer a program for community residential care, and by expanding the VA's ability to provide preventive health-care services; second, by establishing a Veterans' Administration Advisory Committee on Women Veterans and increasing the agency's authority for meeting women veterans' gender-specific health-care needs;



and, third, by enhancing the VA's ability to compete effectively with other entities providing health-care services by improving the agency's recruitment, retention, and personnel management efforts.

The Committee bill would also extend the period for Vietnam-era veterans to request counseling under the readjustment counseling program; express the sense of the Congress with respect to the role of the Administrator of Veterans' Affairs; and require, if feasible, an epidemiological study of the long-term health effects in veterans of exposure to ionizing radiation and the development of a reference guide on that subject.

### *Summary of Provisions*

The Committee bill has seven titles: Title I, Veterans' Administration Health Care Programs; Title II, Provisions to Improve the Recruitment and Retention of Certain Personnel; Title III, Women Veterans; Title IV, Presumption Concerning Dysthymic Disorder; Title V, Status and Role of Administrator of Veterans' Affairs; Title VI, Radiation Exposure Study and Guide; and Title VII, Miscellaneous and Technical Amendments, as follows:

**Title I: *Veterans' Administration Health Care Programs.***—This title would establish new health services programs for veterans and improve existing programs. Included in title I of the Committee bill are provisions that would:

1. Authorize an approximately 4-year pilot program of adult day health care—generally to be provided in non-VA facilities—as an alternative non-institutional form of care for veterans who are eligible for transfer to community (non-VA) nursing homes for care at VA expense.

2. Extend by 1 year the period within which eligible veterans of the Vietnam-era may request readjustment counseling from the VA.

3. Direct the Administrator to conduct a study of the prevalence and incidence of post-traumatic stress disorder in Vietnam-era veterans with particular emphasis on veterans with service-connected disabilities and those who served in Vietnam or the Vietnam theater, and with specific reference to women veterans.

4. Authorize the provision of preventive health-care services to persons otherwise receiving health care from the VA.

5. Make mandatory a discretionary pilot program of preventive health-care services; extend the program, with a \$15 million annual cap on expenditures, through fiscal year 1989; and require the Administrator to provide through the program at least one preventive health-care service to all veterans with 50-percent-or-more service-connected disability ratings otherwise being furnished VA health care for any disability and to all veterans receiving VA care for their service-connected disabilities.

6. Provide for the reimbursement (or direct payment) of reasonable charges for chiropractic services, not otherwise covered by available health insurance or other reimbursement, provided by non-VA providers to certain veterans with neuromus-

culoskeletal conditions of the spine; limit the amount payable for authorized chiropractic services furnished an individual veteran to \$400 per year and the total VA expenditures for chiropractic services to \$2 million in any fiscal year; and establish a September 30, 1987, cutoff date for the provision of chiropractic services for which reimbursement or payment may be made.

7. Expressly provided the VA with authority to conduct a program of referring VA veteran-patients to, and helping them obtain placement in, private, VA-approved community residential-care facilities; and thus codify and clarify the authority for an existing program under which the VA provides veterans with this kind of help.

8. Increase by 15 percent the rates of per diem payments to States veterans' homes—to \$7.30 for domiciliary care, \$13.95 for nursing home care, and to \$15.25 for hospital care—for eligible veterans.

9. Extend for 1 year, through fiscal year 1984, VA authority to provide certain contract health-care services to eligible non-service-connected veterans in Puerto Rico and the Virgin Islands, and require a report by the Administrator, not later than December 1, 1983, on the VA's plans for meeting the health-care needs of veterans in those places.

10. Realign certain resources within the VA health-care budget by requiring that \$20 million in fiscal year 1984 funds be redirected from VA health-care beneficiary travel-expense reimbursements to the provisions of community nursing home care, adult day health care, and preventive health-care services to eligible veterans; require the Administrator of Veterans' Affairs to prescribe regulations that achieve the necessary reduction in beneficiary travel payments; and authorize the Administrator to keep those regulations in effect after fiscal year 1984 if this \$20 million add-on in spending for community nursing home care, adult day health care, and preventive services were achieved as the result of the reduction in beneficiary travel costs.

*Title II: Provisions to Improve the Recruitment and Retention of Certain Personnel.*—This title would revise, extend, and improve various VA programs designed to recruit and retain sufficient and qualified health-care personnel in the VA's Department of Medicine and Surgery. Included in title II are provisions that would:

1. Authorize the Administrator, without regard to civil-service rules, laws, and regulations, to establish the qualifications for and appoint certified or registered respiratory therapists, licensed physical therapists, and licensed practical or vocational nurses in the VA's Department of Medicine and Surgery (DM&S); provide the Administrator with certain new authorities with respect to the promotion and advancement of DM&S personnel in those categories; but require the Administrator to observe principles of veterans preference in the hiring of personnel in those categories.

2. Authorize the Administrator, when and to the extent necessary for recruitment or retention purposes, to use the addi-

tional pay (overtime, weekends, and so forth) authorities for DM&S nurses in compensating personnel in the categories listed in item 1, above.

3. Authorize the Administrator, without the Administrator's action being statutorily subject to review by the President as under current law, to adjust minimum, intermediate, or maximum rates of basic pay for personnel in the categories listed in item 1, above, when necessary for recruitment and retention purposes in certain circumstances.

4. Authorize the Administrator, after considering a potential employee's existing pay or higher or unique qualifications, or the special needs of the VA, to appoint an individual to a position in DM&S providing direct patient-care services or services incident to such direct-care services at a rate of pay above the minimum of the appropriate grade.

5. Require the Administrator and the Director of the Office of Personnel Management to submit a joint report to the Congress on the efforts made to carry out the recommendations made by the VA in the September 1, 1982, report entitled "Study of the Feasibility and Desirability of Converting Selected Health Care Occupations to title 38, United States Code."

6. Require that the majority of individuals serving on a disciplinary board considering charges against DM&S employees in certain categories be in the same occupational category as the employee who is the subject of the charges.

7. Require the Administrator, within 90 days after the date of enactment, to report to the Committees on Veterans' Affairs on the status of the implementation of the provisions summarized in items 1 through 5, above.

8. Require the Administrator, not later than September 30, 1985, to submit a report to the Committees on Veterans' Affairs on the results of the VA's use of the authorities provided in provisions summarized in items 1 through 5, above, and ongoing efforts to develop and carry out programs of education and training for career advancement for certain allied health professionals employed in DM&S.

**Title III: *Women Veterans.***—This title would improve the Veterans' Administration's efforts with respect to women veterans. Included in title III are provisions that would:

1. Provide for the establishment by the Administrator of Veterans' Affairs of an Advisory Committee on Women Veterans (ACWV) to advise the Administrator on the administration of VA benefits for women veterans and their needs for compensation, health care, rehabilitation, outreach, and other VA programs.

2. Require the ACWV to submit to the Administrator by July 1, 1984 and by July each year thereafter, a report which would include an assessment of the needs of women veterans for compensation, health care, rehabilitation, outreach, and other VA programs, a review of VA programs designed to meet those needs, and any recommendations for legislative and administrative actions that the Committee considers appropriate; and require the Administrator within 30 days after receiving

each of these reports, to submit them (together with any comments the Administrator considers appropriate) to the Congress.

3. Authorize the Administrator, until September 30, 1989, to provide certain outpatient care on a fee-for-service basis for a non-service-connected, gender-related disability of a woman veteran, when the VA is unable to provide appropriate care for such disability.

**Title IV: *Presumption Concerning Dysthymic Disorder.***—This title includes a provision that would add dysthymic disorder (or depressive neurosis) to the list of diseases which, in the case of former prisoners of war who were interned for not less than 30 days, are presumed to have been incurred or aggravated by active-duty service.

**Title V: *Status and Role of Administrator of Veterans' Affairs.***—This title includes a provision that would express the sense of Congress that, in light of the size and importance of the Veterans' Administration, the Administrator of Veterans' Affairs should be designated by the President as a member of the Cabinet and be the President's principal advisor on all matters pertaining to veterans and their dependents or survivors.

**Title VI: *Radiation Exposure Study and Guide.***—This title includes a provision that would direct the Administrator, through contracts or agreements, to provide for the conduct—except as determined by the Administrator, with the concurrence of the Director of the Office of Technology Assessment not to be scientifically feasible—of an epidemiological study (or studies) of the long-term adverse health effects from exposure to ionizing radiation from certain detonations of nuclear devices and to develop and publish an indexed reference guide, derived from existing research-result compilations, regarding the state of medical and other scientific information on any long-term adverse health effects in humans from exposure to radiation, including nuclear device, medical, and occupational exposures.

**Title VII: *Miscellaneous and Technical Amendments.***—This title includes one substantive amendment, relating to eligibility for VA health care for certain individuals, and several technical amendments. The one substantive provision would provide for continuing VA health-care eligibility for an individual who suffered injury while receiving VA health-care or vocational-rehabilitation services and would, as a result, be entitled to disability compensation but for the fact that the individual has received a settlement or judgment, but such health-care eligibility would be provided only to the extent specifically provided for in the judgment or settlement.

## DISCUSSION

### TITLE I—VETERANS' ADMINISTRATION HEALTH CARE PROGRAMS

#### *Adult Day Health Care Services*

Section 101 of the Committee bill, which is derived with modifications from title I of S. 578, as introduced, would provide the VA



with authority to conduct a pilot program of adult day health-care services for veterans. Adult day health-care programs provide, in a congregate setting, during normal working hours, health-care services for patients thereby enabling them to be maintained at home in a supportive environment rather than to be institutionalized in a nursing home or hospital.

Adult day health-care programs first appeared in the United States in the 1950's as an alternative to institutionalization for, but not exclusively limited to, elderly patients in need of supportive medical or rehabilitative care to maintain functioning or to continue specific treatment. These programs have differed from senior centers or other social or treatment centers by their strong health-care orientation under medical direction and their emphasis on physiological rather than psychiatric disabilities. Over 800 centers serving approximately 20,000 people daily currently operate in the United States.

During the 1970's, the Department of Health, Education, and Welfare (now the Department of Health and Human Services) supported the development and expansion of adult day health-care services. Limited reimbursement for such services was provided under titles XVIII, XIX, and XX of the Social Security Act and under title III of the Older Americans Act of 1965. Currently, 14 States have been granted "medicaid waivers" to permit the use of title XIX funds for provision of adult day health care as an alternative to institutionalization.

The VA has already initiated adult day health-care programs at four VA Medical Centers to provide medical care appropriate to certain veterans' needs, to shorten the lengths of stay in acute beds when medically indicated; to promote, when feasible, the return of older veterans to their own homes; and to provide an environment in which certain veterans can continue rehabilitation programs among their peers in the community. The VA Medical Center in North Chicago, Ill., has a comprehensive hospital-based adult day health-care program located on the medical center grounds and staffed with a full-time program director, nurse, nursing assistant, recreation therapist and clerk, and a part-time staff of physician, dietitian, social worker, physical therapist, and occupational therapist. Other sites operate at other VA Medical Centers, including American Lake, Wash.; Palo Alto, Calif.; and Butler, Pa.

The services that have been provided in these projects have been carried out under the general authority of chapter 17 of title 38, United States Code, and the health services research authority under section 4101(c)(1) of title 38. Chapter 17 provides express authority for certain long-term care programs, such as nursing home care, community nursing home care, domiciliary care, and State veterans' home care (nursing home, domiciliary, and hospital). However, no specific authority exists under title 38 for the VA to provide adult day health-care services. Section 101 of the Committee bill would provide the Administrator with specific authority under section 620 of title 38, United States Code to conduct a pilot program of adult day health-care services. The authority would allow the Administrator to promote adult day health-care services to certain veterans by contracting for adult daycare in the community and, by establishing and conducting adult day health-care pro-

grams at four VA Medical Centers or outpatient facilities. This authority would expire on September 30, 1987.

The Committee's intention in providing the Administrator with such specific authority is to support and build upon the VA's ongoing initiative in providing adult day health-care services. The Committee particularly encourages the VA to design several approaches for adult day health-care programs to determine the most appropriate, medically efficacious, and cost-effective way, or ways, to provide such services. The Committee's propose in limiting the number of programs located onsite at VA medical facilities is to encourage variety through the use of community programs, to stress the value of keeping veterans involved in their home communities through community-based programs, and to avoid the cost of duplicating already developed approaches. The Committee expects the VA to refer to and seek guidance from the criteria, standards, and regulations used by Federal and State agencies to grant limited reimbursement and "medical waivers" in order to benefit from their existing expertise in supporting adult day health-care services.

Under the new subsection (e) added to section 620 of title 38, United States Code, veterans who are eligible for nursing home care—generally veterans who have received hospital care but still require extended medical supervision—would be eligible for adult day health care. Thus, adult day health care under this provision would be a clear alternative to nursing home placement. While the Committee is aware that there are other categories of veterans who might also benefit from adult day health-care services, this limitation on possible participants is designed to facilitate thorough monitoring and evaluation of this pilot program regarding characteristics of the participants, staff, and health outcomes. In this regard, the Committee notes testimony at the March 9-10, 1983, hearings presented by William Weissert, Ph. D., a senior research associate from the Urban Institute, indicating that very careful targeting of the patient population that is at risk for nursing home administration is a critical factor in determining whether adult day health-care services are a cost-effective alternative to institutionalized care.

At the March 10 hearing, veterans' service organizations voiced their support for the adult day health-care pilot program. Paul Egan, Deputy Director, National Legislative Commission of The American Legion said, "The American Legion has strongly advocated the value of this concept of daytime ambulatory services, . . . The American Legion strongly supports the establishment of such a program within the Veterans' Administration." Donald Schwab, Director, National Legislative Service of the Veterans of Foreign Wars, stated, "The VFW fully supports such a pilot program . . ." and Charles E. Joeckel, Jr., Deputy National Legislative Director of the Disabled American Veterans, said ". . . we are pleased to support the pilot program of Adult Day Health Care."

The Committee is also concerned with the cost of adult day health care relative to nursing home care. The Committee expects that the cost of providing adult day health care for 5 working days, or less, in each week will be substantially less than the cost of providing nursing home care for seven, 24-hour days per week. Therefore, the Committee bill would prohibit placement in adult day

health care if the cost per week of such care exceeds the cost per week of the nursing home care for which it is intended as an alternative. The Committee notes the following testimony regarding this matter:

On March 9, 1983, in testimony before the Committee, Chief Medical Director Donald Custis stated, "We have no sound basis at this point to determine the cost-effectiveness of operating any of the possible types of adult day health-care programs within the VA. Non-VA studies show, however, that adult day health-care programs are cost-effective alternatives to institutional care when viewed on a per patient episode of care basis."

Testimony presented by Sudie Goldston, Chair of the National Institute on Adult Day Care, National Council on Aging, Inc., indicated that the average per diem cost for adult day care is \$20.

Dr. Stanley Korenman, Chief of Medicine at the Sepulveda, VA Medical Center, noted that "the bottom line cost savings will be, as the VA population gets older, the ability to avoid building new beds and hiring new people to take care of inpatients. The preservation of the population in its own home desirable as it is per se, is also desirable in the prevention of increasing the cost to the VA in new construction."

The Committee also believes that a multidisciplinary team approach is essential to sound services and, therefore, intends that health and social services provided by physicians, nurses, and other personnel may include physical and speech therapy, social work, and recreational therapy, midday meals and other medical or rehabilitative services as determined by the Administrator based on the particular medical and rehabilitative needs of program participants. The list of services in the Committee bill is not intended to be exhaustive. The Committee recognizes, for example, that occupational therapists may add an important rehabilitative function.

The Committee agrees with the VA's testimony that access to the program is an important factor in determining program utilization and therefore encourages the VA to ensure that transportation to and from the VA programs whether they be VA facility or community-based, is available to all program participants.

The Committee encourages the VA to examine the possibility of adopting uniform standards for community-based adult day health-care services just as it is authorized to be done by section 106 of the Committee bill for community residential care facilities. These standards would be used in evaluating adult day health-care facilities for purposes of VA placement in order to ensure that appropriate, cost-effective, and high quality medical and rehabilitative services are provided to program participants.

Finally, the Committee bill would require that the Administrator make a report to the Congress regarding the medical efficacy and cost-effectiveness of adult day health-care services provided directly and by contract under the new authority in comparison to the alternative of institutional extended health care. This report would include an assessment of how veterans are selected for participation in the program, in what ways individual veterans' needs and capabilities are considered in selecting an appropriate form of care,



and the extent to which adult daycare services contribute to maintaining older veterans in the community. To the extent practical, this report is expected to rely on quantitative findings of scientific research using classical experimental or quasi-experimental design.

### *Vietnam-Era Veterans' Readjustment Issues*

#### *Readjustment Counseling Program Extensions*

*Extension of Counseling Eligibility Period.*—Section 102 of the Committee bill, derived from section 310 of S. 11, would extend by 1 year, to September 30, 1985, the period of eligibility to request readjustment counseling. It would also extend by 6 months, until October 1, 1984, the date by which the VA must report to Congress on the VA's plans for continuing to provide readjustment counseling after the expiration of that eligibility period.

Public Law 96-22, the Veterans' Health Care Amendments of 1979, provided the authority for the VA to provide readjustment counseling to Vietnam-era veterans. Under that law, eligible Vietnam veterans had 2 years from the date of their discharge or 2 years from a pre-October 1, 1979, discharge (the situation for the vast majority of Vietnam-era veterans), that is until September 30, 1981—to make an initial request for counseling.

In 1981, Public Law 97-72, the Veterans's Health Care, Training, and Small Business Loan Act of 1981, extended the period of eligibility to request readjustment counseling by 3 years, until September 30, 1984. In providing this extension, the Congress recognized that the VA's program for providing readjustment counseling—called the Vet Center program—had, of necessity, taken a considerable time to get underway and begin operating effectively and that there was a continuing need for the services offered by the program. Public Law 97-72 also mandated the VA to study how to meet the Vietnam-era veterans' readjustment needs after September 30, 1984, eligibility expiration date and to submit a report to Congress by April 1, 1984, on its plans in that regard.

At the Committee's March 9 hearings, Dr. Donald Custis, the VA Chief Medical Director, expressed the agency's strong commitment to the program and had, in earlier hearings on February 16, indicated his personal belief that an extension was justified. Subsequently, a VA witness, Dr. Earl Brown, the Associate Deputy Chief Medical Director, testifying on March 24 before the Subcommittee on Hospitals and Health Care of the House Committee on Veterans' Affairs, exhibited a favorable attitude towards the extension. He stated, "In essence, we support the purposes of [a one-year extension] . . . [W]e have experienced a continuing increase in the counseling workload which suggests there remains an unmet need."

At the Committee's March 10 hearing, The American Legion, the Veterans of Foreign Wars, the Disabled American Veterans, the Vietnam Veterans of America, and the American Veterans Committee all testified in support of a 1-year eligibility extension.

John Sommer, representing The American Legion, commented on the increased number of visits to Vet Centers. He stated that as of March 1 the total number of veterans seen had risen to 162,682 representing 722,446 visits—for a total of nearly 181,000 visits in



the first 6 months of fiscal year 1983. This compares to a total of 133,729 visits in the same 6-month period during the fiscal year 1982.

Mr. Sommer explained the Legion's support for this 1-year extension stating:

This continuing influx of Vietnam veterans, the fact that there have been recent changes in the leadership of the readjustment counseling program which have led to the improvement of services, and that some of the Vet Centers have been operational for less than a year, as well as the findings by some mental health professionals that a much higher number of Vietnam veterans than originally estimated are suffering some symptoms of Post-Traumatic Stress Disorder, would lead the Legion to believe that a one-year extension of this program is in order.

In connection with the recent increase in utilization of the program, the Committee considers significant the information in the following table:

TABLE 1.—VET CENTER OPERATIONS

| Fiscal year             | New clients | Total collateral visits, family members, etc. (regardless of length) | Total visits (regardless of length) | Total contacts (visits in units of 15 minutes) | Total visits in units of 45 minutes |
|-------------------------|-------------|----------------------------------------------------------------------|-------------------------------------|------------------------------------------------|-------------------------------------|
| 1980.....               | 28,689      | 15,428                                                               | 79,943                              | 76,467                                         | 76,467                              |
| 1981.....               | 45,637      | 34,528                                                               | 207,768                             | 1,061,478                                      | 353,826                             |
| 1982.....               | 51,025      | 50,948                                                               | 295,202                             | 1,548,696                                      | 516,232                             |
| 1983 <sup>1</sup> ..... | 28,145      | 25,545                                                               | 156,480                             | 739,965                                        | 246,655                             |
| 1983 <sup>2</sup> ..... | 74,300      | 67,440                                                               | 399,900                             | 1,953,500                                      | 651,000                             |

<sup>1</sup> Actual figures for first 5 months of fiscal year 1983.

<sup>2</sup> Projection for fiscal year 1983 based on experience in the first 5 months, taking into account the time required for the 27 vet centers which have opened during the past 1½ months to get to full operation and expected increase in productivity overall.

Source: Veterans' Administration, Department of Medicine and Surgery.

The Committee also notes that the first Vet Center did not open until January 1980 and that quite a few centers have now been open for less than a year. According to the VA, as of March 1983, the 136 Vet Centers and satellites had been open an average of 27.7 months. The agency further reported that 28 of these Centers were opened in calendar year 1982 and that as of March 1983 those 28 had been open an average of only 10.5 months. Thus, the proposed extension would give the program at its present size the stability necessary to identify and serve the needs of eligible veterans as well as giving veterans in areas where Vet Centers have recently opened a fair opportunity to benefit from the program.

The Committee notes a further basis for this extension in the views of the Vietnam Veterans of America. In response to a follow-up question from the March 10 hearing, the National Women's Director of that organization, Lynda Van Devanter, expressed the organization's support generally for the extension of the eligibility period for requesting readjustment counseling, saying that "every indication is that the need for the Vet Centers has not even peaked yet." Of particular interest and concern to the Committee was the information she presented on the status of outreach efforts to

women veterans, which, she explained, have taken longer to get underway than that for male Vietnam Veterans. She stated:

The first year of the program saw almost no women veterans entering the program, since the counselors within the program had received no training in dealing with women veterans. In the second and third years, the program began seeing women, but the organized working group on women veterans did not meet for the first time until September of 1982 to address the continuing problems for women veterans in the program. Only now, in the past month, have the recommendations of the working group begun to be implemented in the area of training. There has been minimal outreach to this population, another of the recommendations of the working group. That is also just beginning to be addressed.

The present director of the Vet Center program, Dr. Arthur Blank, has been very supportive of the working group and its recommendations. But, again, it takes time to implement changes, even with his active support. It may take another nine months or a year before training is complete and outreach materials have been developed and distributed. By that time, the program would be on the downturn, and the women would, again, be left out.

Representing the American Veterans Committee, June Willenz expressed in a followup letter to the March 10 hearing her support for the extension of the readjustment counseling program, stating that

[P]articularly because the Readjustment Counseling Program has only in the last few months begun to address the problems and needs of the Vietnam era women veterans, it is essential to give the program a chance to reach out to many more women veterans who need help in their readjustment. Only recently have the medical and social work professions begun to realize that the women veterans who served during the Vietnam era have been subject to the same or similar stress disorders as the men veterans who served.

In a similar vein, there has been growing sensitivity and awareness in the VA generally, and in the Vet Centers and Medical Centers particularly, to Post-Traumatic Stress Disorder (PTSD). This disorder was first officially recognized in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition), published in 1960. One indication of the scope of the prevalence of PTSD generally is that from the time of official recognition to April 5, 1983, the VA has allowed 5,780 compensation claims for PTSD. Because a common point of initial contact with the VA for Vietnam veterans suffering from PTSD is through the Vet Centers, the Committee believes that this avenue of approach should not be closed at a point when greater assistance and understanding is becoming available.

The Committee also believes that the Vet Centers, in addition to their primary missions of outreach and readjustment counseling, have an important role to play in connection with the epidemiological study of Vietnam veterans which was mandated by Public Law 96-151 and authorized to be expanded by Public Law 97-72 and which is currently being conducted by the Centers for Disease Control. The Committee believes very strongly that this is a vitally important study since it is the major one underway or planned which relates directly to the current health status of Vietnam veterans. As one of the principal contact points for Vietnam veterans within the Veterans' Administration, Vet Centers have the potential of providing greatly needed assistance in locating individuals and in encouraging participation in this long-awaited study as well as of keeping veterans informed regarding progress on and results of this and other studies. Thus this is yet another basis for extending the eligibility period for requesting readjustment counseling.

Finally, it appears clear that the need for readjustment counseling among some Vietnam veterans is a continuing one. This need is confirmed not only by the increasing numbers of Vietnam veterans being seen in the centers, but by events, such as the National Salute to Vietnam Veterans last November, and the growing public recognition of Vietnam veterans which have been important in allowing many Vietnam veterans to acknowledge their service and, in so doing, to recognize that they have some unresolved feelings about it and the recognition—or more frequently, lack of recognition—they received for that service from their fellow citizens.

#### *Extension of Report Deadline*

The Public Law 97-72 amendments to the readjustment counseling authority contemplated a thoughtful, comprehensive evaluation, over the period of the extension of eligibility provided in that law, of the impact of the agency's readjustment counseling efforts and alternatives for the future evolution of these efforts. Given the fact that the program has taken a considerable amount of time to get underway and begin operating effectively, a further extension at this time would seem appropriate in order to give the Veterans' Administration sufficient time to examine and evaluate the program thoroughly before making any recommendations or plans regarding the future of the program.

Extending the period between the due date of the Veterans' Administration's report and the expiration of the period to make the initial request for counseling would give the Congress a better chance to review various alternatives for the future. The deadlines in current law—under which the report is due on April 1, 1984—would provide the Committees on Veterans' Affairs of the Senate and the House of Representatives only 45 days from the due date for the Veterans' Administration's recommendations until the May 15 deadline, imposed by section 402(a) of the Congressional Budget Act of 1974, to consider reporting legislation, such as would be entailed in an extension of the eligibility date, or otherwise to address legislatively the future of the Veterans' Administration's readjustment counseling efforts.

The Committee notes that the Veterans' Administration established the Readjustment Counseling Planning Task Force in Febru-



ary 1983, to make recommendations to the Chief Medical Director on all program developments of the Vet Center program. The Committee strongly urges that the Task Force address the issue of transferring the program from "storefront counseling centers" to Veterans' Administration medical centers and include the options considered and a plan to address these options in its final report. The Task Force report, according to answers provided by the Veterans' Administration to followup questions submitted after the March 9 and 10 hearings, will be completed in the fall of 1983. The Committee stresses the importance of adherence by the Task Force to this projected completion date to enable the Chief Medical Director to submit his recommendations to the Administrator in time for review and preparation of the report to Congress, extended by the Committee bill to October 1, 1984. Finally, the Committee recommends that the Task Force also include in its report an evaluation of the Vet Center program, including services offered, personnel training and morale, budget, program utilization, outreach efforts, linkages between the Vets Centers and the Veterans' Administration's medical centers, and the operation of the fee-for-service program.

#### *Study of Post-Traumatic Stress Disorder*

As discussed above, it was only after many years of debate that legislation authorizing the VA to provide readjustment counseling was finally enacted in 1979. As the Committee noted in the report on the measure (S. 7) that became Public Law 96-22, the primary purpose of the readjustment counseling provisions in the law was to assist "those Vietnam-era veterans who feel the need for counseling to help them in their readjustment to civilian life". (S. Rept. 96-100, 96th Cong., 1st Sess., p. 27.) The Committee described a "readjustment problem" which readjustment counseling was intended to address, as:

a low-grade motivational or behavioral impairment which interferes with a veteran's normal interpersonal relationships, job or educational performance, or overall ability to cope reasonably effectively with his or her daily life problems. Id.

Since the establishment of the Vet Center program, knowledge about the readjustment difficulties of Vietnam-era veterans has come about from the VA's experience with the program and through related inpatient efforts as well as activities outside the VA—such as the study on the readjustment of Vietnam veterans prepared by the Center for Policy Research, entitled "Legacies of Vietnam: Comparative Adjustment of Veterans and Their Peers" (March 26, 1981, Senate Committee Print No. 6, 97th Congress, 1st Session), and other ongoing research on Vietnam veterans. Thus, it has become known that Vietnam-era veterans have experienced and continue to experience a wide spectrum of readjustment responses to their service, ranging from complete reintegration, on the one hand, to suffering from post-traumatic stress disorder (PTSD) to a severely disabling degree, on the other. It also now appears clear



that those who saw combat in Vietnam are more likely to be experiencing the more significant difficulties. What is not known, however, is the prevalence and incidence of PTSD in the Vietnam-era veteran population, the effects of various levels of PTSD severity in terms of the veteran's ability to function in society, or the VA's capacity to provide assistance, either through the Vet Center program or otherwise, for veterans suffering from PTSD or related readjustment assistance.

To remedy this information gap and in connection with the extension of the readjustment counseling eligibility authority proposed in section 102 of the Committee bill, section 103 of the Committee bill would require the Administrator to carry out a study on the issue of PTSD and related readjustment problems of Vietnam-era veterans. The purpose of this study would be to determine the prevalence, incidence, and effects of PTSD and related readjustment problems. The Administrator would be required to place particular emphasis on veterans with service-connected disabilities, those who served in Vietnam or elsewhere in the Vietnam theater of operation (for example, on a Navy ship in the South China Sea or with an Air Force squadron in Thailand), and consider the problems of women veterans. These particular emphases should ensure that information is developed to assist the VA in evaluating the effectiveness of past efforts to provide assistance to veterans in the groups involved and, to the extent particular problems are identified in one or another of the specific groups, to fashion appropriate remedies.

Section 103 of the Committee bill would also require the Administrator to report to the Congress, not later than March 1, 1985, on the results of the study, to include information on the VA's ability to provide treatment to the numbers of veterans identified as suffering from PTSD and related readjustment problems. The information in this report should be of significant use to the Committee and the Congress in considering the future shape and direction of the readjustment counseling program.

In addition, the Administrator would be required to include in the report a description of VA policies and procedures for providing disability compensation to individuals suffering from PTSD or related problems and on activities intended to coordinate VA health-care and compensation programs with respect to PTSD. This requirement reflects the Committee's view that VA compensation and health-care activities and policies should be more closely coordinated so that benefits under the two areas are available as appropriate. Vietnam veterans located in various geographic areas have indicated that such coordination does not exist at present. Indeed, it has been suggested by some veterans that there appears to be a significant tension between VA health-care personnel and VA adjudicators regarding PTSD and that while health care for treatment of a particular veteran may be available based on a veteran's suffering from service-connected PTSD, the veteran is unable to have the disability adjudged service-connected for compensation purposes. The Committee is concerned that, to the extent that such a situation exists, it should be corrected and believes that

a study which would expand the knowledge of PTSD would aid in this effort. The Committee emphasizes that the VA should continue its efforts to transmit any available information to VA health-care personnel and claims adjudicators on PTSD in order to aid in the furnishing of mental health services and in the fair and consistent adjudication of claims.

As a final point with reference to PTSD, the Committee renews its support for the establishment within the VA of a center for post-traumatic stress disorder. Such a center was first discussed in the report accompanying S. 921, legislation which provided for a 2-year extension of eligibility for readjustment counseling. (S. Rept. No. 97-89, 97th Cong., 1st Sess., p. 17). The Committee there noted:

Such an entity would be helpful not only to Vietnam-era veterans but could also serve as a center for the treatment of other veterans suffering from stress disorders occasioned by intense combat or by incarceration as a prisoner of war, as well as a training center for mental health practitioners who would be working with such individuals. *Id.*

The Committee continues to believe that the establishment of such a center of excellence could have significant long-term benefits for the VA's understanding of the source and impact of this disorder and on the development of appropriate treatment approaches, and again urges that the VA give serious consideration to the establishment of such a center.

### *Preventive Health-Care Services*

#### *Background*

Section 104 of the Committee bill contains two provisions, derived from section 302 of S. 11, as introduced, which are designed to improve veterans' access to preventive health-care services through the VA. The first provision would authorize the VA, as a matter of discretion, to furnish preventive health-care services to veterans otherwise receiving VA care and services. The second provision would modify an existing preventive health-care pilot program—enacted in 1979 as part of Public Law 96-22—targeted on veterans with service-connected disabilities rated at 50 percent or greater and veterans receiving VA care for the treatment of service-connected disabilities, so as to make mandatory this discretionary pilot program. Under the pilot program as so modified, the Administrator would be required to provide at least one preventive health-care service to all veterans with service-connected disabilities rated at 50 percent or greater who are otherwise receiving VA care and to all veterans receiving VA care for their service-connected disabilities. In addition, and as considered appropriate by the Administrator, the VA could provide preventive services under the pilot program to veterans in either of these two categories who are not otherwise receiving VA care.

In this era of increased emphasis on reducing the cost of medical care and increasing efforts in health programs in general in the United States to prevent disease and disability, the Committee believes that the VA has a special responsibility—because of its size, the number of individuals it treats annually, and its significant re-

sponsibility, through active affiliations with health-care training institutions, for the training of our Nation's health-care providers—to try to learn more about the impact, in terms of cost and improved health, of providing preventive health-care services to veterans eligible for VA care.

The Committee notes that it expressed similar views in the Committee report accompanying S. 7, the legislation that was ultimately enacted as Public Law 96-22 (S. Rept. No. 96-100, 96th Cong., 1st Sess., pp. 40-47). Nevertheless, despite the Committee's interest in the pilot program, the VA has done virtually nothing to date to utilize the program authority provided in that legislation. In response to a question following the March 9 hearing, the VA indicated that, during the period from when the pilot program was first authorized in 1979 to the present, the agency has funded only six studies—costing a total of \$1.2 million. Further, based on a review of the limited information provided by the VA in that response, it is not clear to the Committee whether each of the studies is actually directly related to preventive health care. The Committee views the agency's performance in this regard as disappointing.

Dr. Morris E. Chafetz, President of the Health Education Foundation, in testimony submitted to the Committee in connection with the hearings on March 9-10, 1983, made the following point:

Prevention . . . embodies techniques representing the use of strategies designed to protect the health of the Nation's veterans while, at the same time, offering a plan for a sensible program that would help to control the runaway costs of our present sickness-care system.

Dr. Lester Breslow, the former Dean of the School of Public Health at the University of California at Los Angeles and now a professor there, also submitted comments to the Committee in connection with its consideration of this provision. He noted that "a vast and growing amount of . . . medical evidence indicates the importance of the (proposed) preventive health-care services". Dr. Breslow went on to assert that "(a) substantial proportion of major, current, fatal disease cases, namely, those affecting the cardiovascular system and cancer, can be prevented from taking their toll". The Committee also notes that the witnesses at the Committee's March 10 hearing representing the American Legion, the Veterans of Foreign Wars, and the Disabled American Veterans all expressed support for the VA's providing preventive health-care services. The Committee emphasizes its intention and expectation that, under the provisions in the Committee bill, the VA will place greater emphases both on providing preventive health-care services to eligible veterans and on seeking to determine the health effects of providing such services.

#### *Committee Bill Provisions*

The Committee notes that the provisions in the Committee bill would result in two separate, though interrelated, authorities. Under the amendment to the title 38 definitional provision relating to what services are authorized to be provided as part of VA health care, the agency would be given new, discretionary authority to provide preventive health-care services to any veteran otherwise



receiving VA medical services. The decision as to what services to offer would be left to the VA as indeed would the decision whether to offer any such services. In the agency's testimony prepared for the March 9 hearing, the point was made that the VA did not intend to use the authority to provide preventive health-care services "to provide at large the wide range of services listed in section 662 of title 38." The Committee stresses that it has not indicated any intent to the contrary and that the list of services in section 662 is simply a list of possible preventive services. Thus, even under the mandatory pilot program, discussed below, the VA would retain the discretion in establishing the nature and mix of services to be provided.

Under the second amendment, which makes the present preventive health-care pilot program mandatory and extends it for 4 more years, the VA would be required to offer at least one preventive health-care service to certain veterans receiving VA care—those with service-connected disabilities rated at 50 percent or greater than those receiving VA care for their service-connected disabilities. The decision as to what preventive service or services to provide would rest solely with the VA.

With reference to one item on the list of services in present section 662 of title 38—namely, periodic medical and dental examinations—the Committee repeats the point made in its 1979 report that "(t)his does not mean an annual physical—a costly procedure which experience has shown does not ensure freedom from serious illness." (S. Rept. No. 96-100, 96th Cong., 1st Sess., p. 41.) Rather, the continuing inclusion of this item in the list of preventive services is designed to authorize periodic screening visits, with appropriate VA health-care personnel, geared to groups of patients on the basis of age or some other common attribute related to the desirability of the examination in question.

The Committee notes that, on the basis of a concern expressed by the VA and shared by the Committee, a significant change was incorporated in the provision in the Committee bill relating to the pilot program. In response to a March 9 hearing followup question about the agency's opposition to a mandatory prevention pilot program, the VA stated that "(t)he thrust of prevention-oriented services is one of outreach to persons currently not under the care of health professionals and creates a new population seeking care." Although this statement may have some validity as a general matter, the provision in the Committee bill was modified as discussed above, so that the mandatory aspects of the pilot program are limited to veterans in target population who are already receiving VA care. The Committee believes that this modification is responsive to the VA's concerns on the point and should ensure that the agency's efforts to provide preventive health-care services will not generate significant new expenditures by stimulating new sources of demand for VA care.

The Committee recognizes that there is a great deal to learn about the best way to provide preventive health-care services and the cost-effectiveness and practicality of various services. Nevertheless, the Committee is satisfied that there is a significant role for such services that already are known to be simple, inexpensive, and cost-effective (such as hypertension, glaucoma, and colon



cancer screening procedures) and believes that the provisions in the Committee bill will provide a basis for needed further development within the VA. Together, the two amendments are designed both to expand the opportunities for the VA to furnish preventive services and express a clear Congressional mandate and expectation that meaningful efforts to develop and provide such services—and to conduct appropriate studies of their effectiveness—will be undertaken.

### *Chiropractic Care*

S. 567, as introduced by Committee member Senator Strom Thurmond on February 23, 1983, would have amended title 38 to provide for reimbursement (or direct payment) of reasonable charges for chiropractic services, not otherwise covered by available health insurance or other reimbursement furnished (prior to September 30, 1987) to certain veterans with neuromusculoskeletal conditions of the spine; and would limit the amount payable for such services furnished an individual veteran to \$600 per year and total Veterans' Administration expenditures for chiropractic services of \$2,000,000 in any fiscal year. In his introductory remarks, Senator Thurmond discussed the need for including chiropractic services as a title 38 health care benefit, in the following terms:

... I believe our Nation's veterans deserve the same access to medical treatment, including chiropractic treatment, as do recipients of other Federal and State health care programs, many of which now provide chiropractic treatment to their beneficiaries. It is time that the Veterans' Administration's policy and practice be brought more in line with these programs. For instance, under the medicare program which is administered by the Department of Health and Human Services (HHS), it is typical for eligible persons in need of chiropractic care to seek and obtain the services of a doctor of chiropractic and to receive reimbursement for such services from HHS. Reimbursement for chiropractic services is also currently provided under the Federal Employees Compensation Act and a number of States include chiropractic services under their medical assistance programs.

It is the understanding of the Committee that the Veterans' Administration has the general authority, which it has to date chosen not to use, to provide chiropractic services directly through chiropractors who may be employed as part of hospital care as defined in section 601(5)(A)(i) of title 38 and medical services as defined in section 601(6), to any veteran eligible to receive such care or services who is in need of chiropractic services, and to provide such chiropractic services on a contract basis under the general criteria prescribed in section 601(4)(C) for the provision of care and treatment on a contract basis.

The Veterans' Administration, in its testimony before the Committee at the March 9 and 10 hearings, acknowledged previous urgings by the Committee to reevaluate its position on the use of existing authority to provide such services. The Veterans' Administra-

tion states that its studies of chiropractic and reviews of the literature have "ultimately reaffirmed the validity of the objections" previously expressed. The Committee disagrees with the Veterans' Administration's position that it should refuse to provide chiropractic services in every case and believes that chiropractic services for the treatment of musculoskeletal conditions of the spine may be beneficial and even necessary in some cases.

Since the Veterans' Administration continues to hold to its previous position of not using existing authorities to provide, on a pilot basis, chiropractic services in appropriate cases as part of the hospital care or medical services furnished to veterans, the Committee has included provisions, derived from S. 567, in the Committee bill as section 105, which would authorize reimbursement (or direct payment) for the reasonable charges, within certain prescribed limitations, for chiropractic services furnished certain eligible veterans.

Under the Committee bill, the term "chiropractic services" is defined, under clause (9) which would be added to section 601 as "the manual manipulation of the spine performed by a chiropractor, who is licensed as such by the State in which he or she performs such services and who meets the minimum standards promulgated for chiropractors under section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5)), to correct a subluxation of the spine": For the purposes of the new authority, this term does not include "physical examinations, laboratory tests, radiologic services, or other tests or services determined by the Administrator to be excluded." Hence, the only services for which reimbursement or payment is authorized would be spinal manipulation as treatment for a neuromusculoskeletal condition.

New section 630A would require the Administrator, under regulations the Administrator would prescribe, to reimburse veterans eligible for medical services under chapter 17 of title 38, United States Code, for the reasonable charge for chiropractic services for which a veteran has made payment or for the direct payment of a chiropractor for such services if such services were for (1) the treatment of a service-connected neuromusculoskeletal condition of the spine, or (2) the veteran has been furnished hospital care by the Veterans' Administration for a neuromusculoskeletal condition of the spine within a 12-month period prior to the provision of chiropractic services, or (3) the veteran has a 50-percent or greater service-connected disability and has been furnished hospital care or medical services by the Veterans' Administration for a neuromusculoskeletal condition of the spine. Such reimbursement would be provided only to the extent that the veteran is not entitled to such chiropractic services or reimbursement or payment for the expenses of such services under health insurance or other form of third party health-care coverage. Thus, under the Committee bill, the veteran must have been determined by the VA to have a neuromusculoskeletal condition of the spine. In all likelihood, the veteran would have been given an x-ray examination by the VA at some time prior to such veteran being eligible for reimbursement or payment for chiropractic services under the proposed Committee provision.

In determining the reasonable charge for chiropractic services, the Administrator would be required to consult with appropriate public and nonprofit private organizations and other Federal departments and agencies that provide reimbursement for chiropractic services (such as the Social Security Administration in the Department of Health and Human Services and the Office of Workers' Compensation Programs in the Department of Labor), and to then establish a schedule of allowances for such services consistent with the reasonable charges allowed under title XVIII of the Social Security Act (42 U.S.C. chapter 7), which the Committee understands are established under section 1842(a)(3)(B) of that Act (42 U.S.C. 1395(e)(3)(B)). Annual reimbursement or payments on behalf of an individual veteran would be limited to \$400. Total expenditures in any fiscal year for chiropractic services could not exceed \$2 million and no reimbursement would be authorized for any chiropractic services furnished after September 30, 1987.

With reference to the need for the VA to monitor the performance of fee-basis chiropractors providing services under this new authority, the Committee notes the testimony of the VA's Chief Medical Director at the Committee's March 9 hearing, during which he noted the problems that VA medical professionals would face in monitoring chiropractors. In Dr. Curtis' view, the provision of care by "the theories and the basis upon which allopathic medicine is based" are so different from the theories and basis of chiropractic medicine that members of the medical profession "should not stand in judgment" of the care that chiropractors provide. In light of this situation, the Committee recommends that the procedures the VA establishes to ensure the quality and appropriateness of care delivered by chiropractors at VA expense under this authority provide for the monitoring of such care by doctors of chiropractic whose credentials are as prescribed by the Administrator.

Finally, to enable the Committee to make an informed judgment as to the need to continue or amend the authority for furnishing chiropractic services beyond the proposed statutory termination date of September 30, 1987, the Committee bill would require the Administrator to submit to the House and Senate Committees on Veterans' Affairs, not later than December 31 of each of the authorized years, an annual report regarding the utilization of chiropractic services under the new authority.

### *Community Residential Care*

Section 106 of the Committee bill, which is derived from title II of S. 578 as introduced, would clarify and codify the VA's authority to administer a community residential-care program. The provision in S. 578 as introduced was proposed by the Administration in a February 17, 1983, submission from the Administrator of Veterans' Affairs.

In 1951, the VA instituted trial community visits for certain psychiatric patients to provide an intermediate step toward maximum community adjustment by allowing the patients to reside in a semi-independent living situation. This so-called "foster care program" provided an alternative to institutional care and enabled 185 pa-



tients, who did not have their own homes, to experience a family-like environment.

Since that time, the VA has continued to support programs whereby the agency referred patients to community homes when institutionalization was no longer required. In October 1975, the VA's Chief Medical Director issued a letter to VA medical facility directors urging the expansion and development of "personal care" as an institutional alternative for medical and surgical patients, thereby establishing the Personal Care Home Program for psychiatric, medical, and surgical patients who could benefit from non-institutional care but who lacked family or other support networks in the community.

The residential-care program, as it is presently called, provides residential care, including room, board, personal care, and general health-care supervision to veterans who do not require hospital or nursing home care but who, because of health conditions, are not able to resume totally independent living and have no suitable family resources to provide the needed care in a home setting. All homes are inspected by a VA multidisciplinary team prior to being incorporated into the program and annually thereafter. Care is provided, at the veteran's own expense, in private homes selected by the VA. Veterans receive monthly followup visits from VA social workers and other health-care professionals, and generally are outpatients of the referring local VA facility. An approximate average daily census of 12,500 was maintained in this program in fiscal year 1981.

VA figures indicate there are approximately 12,700 veterans currently in residential-care facilities with 3,058 homes participating in the program. Eighty-seven percent of these veterans have psychiatric diagnosis or organic brain diseases, approximately 9 percent have medical or surgical primary diagnoses, and the remaining 4 percent have substance abuse or other diagnoses. Approximately 75 percent of the veterans in residential-care facilities were referred directly from a VA medical center with the remainder of the referrals being evenly divided between other VA programs and other sources in the community. The average age of veterans placed in the program varies according to diagnosis. The average age of veterans at the time of placement for organic brain disease is 62 years, for medical or surgical disabilities is 55 years, for psychiatric problems is 53 years, and for substance abuse is 49 years. Thirty-five percent of the veterans with psychiatric diagnoses has a length of stay greater than 5 years. Other patient groups exhibited shorter lengths of stay. For example, 46 percent of the medical or surgical participants has been in the program for less than 1 year. Veterans who are rated incompetent to handle funds accounted for 63 percent of the total population.

A June 6, 1978, report to Congress by the Comptroller General, entitled, "Better Services At Reduced Costs Through An Improved 'Personal Care' Program Recommended For Veterans" (GAO-HRD-78-107), recommended that Congress provide specific legislative authority for this program.

Even though the VA has been administering various forms of the program since 1951, the Committee believes it important that specific legislative authority be provided for the VA to administer the



program, and specifically to set program standards, establish guidelines for procedures involving the approval of the residences, conduct annual inspections, examine services received by the veterans within the facilities, and to assist in the removal of the veteran from the facility where necessary.

Section 106 of the Committee bill would expressly and specifically authorize the VA to promulgate regulations establishing standards for use in evaluating residential-care facilities for purposes of VA-initiated placements. These standards would include criteria for health and safety; costs of care, supervision, and other services; resources that a facility needs in order to provide an appropriate level of services; and other factors which the Administrator would determine to be appropriate to protect the welfare of veterans placed in community residential facilities. In this connection the Committee notes its intention that the regulations provide the means of ensuring that the facilities to which veterans are referred are located in residential neighborhoods or other community-based settings that provide a normal, safe, and psychologically healthful environment for the residents.

This authority would affect only those facilities wishing to receive referrals from the VA. A facility's participation in a VA assessment of standards would remain entirely voluntary, and its operators would be under no obligation to accept any recommendation by the assessment team. Those facilities that do participate but are found not to comply with VA standards would receive notice and an opportunity for a hearing prior to the cessation of referrals from the VA.

On March 9, 1983, in testimony before the Committee, the VA's Chief Medical Director, Dr. Donald Custis, stated, "The Veterans' Administration has a special responsibility to protect the interest of veterans referred to community residential facilities because of their vulnerability." The American Health Care Association (AHCA), a federation of 8,000 members which operates long-term care facilities, including residential-care facilities, in comments submitted to the Committee concerning the provision in the Committee bill, supported the development of a program to formalize the VA's referral services for residential-care facilities. AHCA recommended, however, that the VA accept state licenses as an assurance that a facility meets adequate standards for care. Although the Committee agrees that licensure by a State should be given full consideration by the VA—and new section 630(b)(2)(A) would require VA standards to include "a requirement of compliance with applicable state laws and local ordinances relating to health and safety", the Committee nevertheless believes that it is both appropriate and necessary for the VA to establish uniform guidelines for VA evaluations as to the compliance of participating residential-care facilities with health and safety standards promulgated by the VA in order to attempt to ensure the safety and well-being of the veterans placed in residential-care homes. At the March 10, 1983, hearing, representatives of The American Legion and the Disabled American Veterans expressed support for this provision and the representative of the Veterans of Foreign Wars expressed strong support for it.

The Committee emphasizes that the participation in this program of both the veterans and the facilities is purely voluntary and that all expenses are paid for by the veterans. The Committee intends that the standards established by the VA serve as a useful administrative tool in evaluating residential-care facilities in terms of health and safety protection for the veteran without imposing any undue burdens on the participating residential-care facilities. The committee strongly supports the use of noninstitutional forms of long-term care for veterans when appropriate and believes that the application of these standards in evaluating residential-care facilities for purposes of placements initiated by the VA would aid in providing such care to veterans in need of a semi-independent living environment.

#### *Increase in Per Diem Payments to State Homes*

Section 107 of the Committee bill, which is derived from S. 629, would provide for a 15-percent increase in the per diem rates paid by the Veterans' Administration to State homes for veterans for the care of eligible veterans. Under the Committee bill, the per diem rates would be increased from \$6.35 to \$7.30 per day for domiciliary care, from \$12.10 to \$13.95 per day for nursing home care, and from \$13.25 to \$15.25 per day for hospital care. These proposed rates, which are related to the level of care being provided to the veteran, would take effect during the period April 1 through September 1, 1984, depending on the timing of specific appropriations for that purpose.

The Committee believes that this increase in the per diem rates is fully justified in light of the importance of the State home program in overall efforts to meet the health-care needs of the aging veteran population. The Committee notes two critical factors which contribute to the need for an increase in the per diem rates for State Veterans homes. First, the number of veterans over age 65 continues to rise at a significant rate, and it is expected that the demand for acute and long-term health-care services will dramatically increase. And second, since October 1980, the effective date of the last increase in these per diem rates, inflation has diminished the ability of State homes to provide care for eligible veterans and the 15.9-percent rise in the Consumer Price Index from October 1980 through March 1983 has already significantly reduced the buying power of the Federal Government's per diem payment to the State homes. Although it is not possible to project accurately the inflation effect that will have occurred by the time the proposed rates would take effect, the Committee is concerned that, if this trend were to continue, there might be an unwillingness of States to maintain existing homes. Alternatively, in the cases of those States without existing facilities, there might be a reluctance to develop facilities and to become involved in the program. Such results could have serious implications for the Nation's overall ability to meet the extended care needs of the aging veteran population. On this point, the Committee notes the testimony of the Deputy Administrator of Veterans' Affairs, Everett Alvarez, Jr., before the Subcommittee on Hospitals and Health Care of the

House Committee on Veterans' Affairs on February 16, 1983, when he stated:

The State Home Program has long been recognized as an important auxiliary resource for meeting the extended care needs of our aging veteran population. Indeed, current VA planning anticipates continued growth in this program.

If this planning goal is to be realized, the Committee emphasizes that the Federal Government must continue to be an active partner with the States, and the proposed increase in the per diem rates is designed to continue that effective partnership. The Committee fully supports the State Home Program and endorses its continuation as an important community link in meeting the needs of our aging veteran population.

The Committee has made the increase effective on September 1, 1984; however, if funds are specifically appropriated to make it effective earlier, it could, under the Committee bill, become effective as soon as April 1, 1984 (the same effective date as would have been operative under S. 629).

### *Health Contract Care in Puerto Rico and the Virgin Islands, and Territories*

#### *Background*

Section 108 of the Committee bill, which is derived from S. 664 as introduced, would extend by 1 year, until September 30, 1984, the VA's authority to contract for the furnishing on the Commonwealth of Puerto Rico and in the Virgin Islands (and other territories and possessions of the United States) of hospital care for the care of non-service-connected disabilities and such medical services as will obviate the need for hospital admission for the care of such disabilities.

Amendments made by section 4 of Public Law 97-251, the Veterans' Administration Health-Care Program Improvement and Extension Act of 1982, extended until September 30, 1983, the VA's authority to contract with private facilities for the provision of hospital care and such outpatient medical services as would obviate the need for hospital care for the treatment of non-service-connected disabilities in any Territory, Commonwealth, or possession of the United States not contiguous to the 40 contiguous States.

A General Accounting Office report completed on March 30, 1978, on the Veterans' Administration's use of its then-existing contract authority to provide non-service-connected care in Puerto Rico and the Virgin Islands, and which is discussed in more detail in the Committee's report accompanying H.R. 5029 (S. Rept. No. 95-825, 95th Cong., 2nd Sess., p. 24-26), concluded that "a comprehensive assessment is needed of the health-care needs of veterans in Puerto Rico and the Virgin Islands". In response to this recommendation, the Congress directed the Veterans' Administration to conduct a study on health care for veterans in Puerto Rico and the Virgin Islands, a report of which was submitted to Congress on April 9, 1981. The report, which is discussed in more detail in the Committee's reports accompanying S. 921 (S. Rept. No. 97-89, 97th



Cong., 1st Sess., p. 8) and S. 2385 (S. Rept. No. 97-467, 97th Cong., 2d Sess., p. 19), identified the following major problems for the Veterans' Administration with regard to providing health care to veterans in Puerto Rico and the Virgin Islands: (1) Low quantity and quality of non-Veterans' Administration psychiatric care; (2) inadequate ambulatory care facilities; (3) near absence of nursing home beds; (4) inaccessibility of health care outside the VA; and (5) isolation of Virgin Islanders. The report listed four options for inpatient care, six options for outpatient care, and five options for nursing home care, including estimated construction costs and recurring operating costs.

So that the Committee and the Congress could have sufficient time to weigh these various options and select the most appropriate course for meeting the health-care needs of veterans in these locations, the contract non-service-connected care authority was extended by Public Law 97-72 until September 30, 1982, and because of the complex nature of the potential impact of the various options, such authority was again extended by public law 97-251, until September 30, 1983. In an explanatory statement which outlines the House and Senate compromise on the final bill which became Public Law 97-251 (Congressional Record, August 18, 1982, p. S11064), the House and Senate Veterans' Affairs Committees noted that this was the second, consecutive short-term extension of this authority and that it was likely that further extension would be required before a permanent approach to providing appropriate and cost-effective health care to veterans in those locations could be developed. In order to move towards such an approach as quickly as possible, the Committees considered it imperative that the VA take immediate steps to develop a comprehensive plan for providing such care and, to the extent that a new construction would be involved, prepare the needed project proposals for inclusion in the President's fiscal year 1984 budget. In order to be able to evaluate the VA's proposal in this regard prior to the time that a further, short-term extension of the fee-basis authority would be required, the Committees directed that by December 1, 1982, the agency provide them with a specific, detailed proposal, including any construction project that the VA considered necessary, pertaining to health care for eligible veterans in Puerto Rico and the Virgin Islands and, most particularly, for meeting the health-care needs of those veterans in that population who have service-connected disabilities.

#### *VA 1983 Options Reports*

The VA report, "A plan for the Delivery of Health Care to Veterans in Puerto Rico and the Virgin Islands", was submitted to the Veterans' Affairs Committees on January 20, 1983. The report addressed the problems which impeded veterans' access to health care in Puerto Rico and the Virgin Islands and provided a plan of action for hospital inpatient, outpatient, and nursing home programs, including three construction options. The report outlined certain guidelines to provide direction for the VA during preparation of specific recommendations on the health care of veterans in Puerto Rico and the Virgin Islands: (1) to the extent practical, all VA health-care services in Puerto Rico should be provided in VA-



operated facilities; (2) the present utilization of health care provided under VA auspices is currently the best available indicator of need; (3) a veteran population of 130,000 in Puerto Rico, based on 1980 census information, will be used for planning; (4) the Medical District Initiated Program Planning (MEDIPP) process and methodologies should be adhered to as closely as possible; and (5) the potential for sharing arrangements for inpatient, outpatient, or nursing home care with any of the branches of the military is lacking. In addition, the plan suggested that the VA realign existing space and construct new space in the VA Medical Center in Puerto Rico to provide all inpatient bed needs, provide care at projected 1990 levels in the Mayaguez Clinic, place a VA-operated clinic in Ponce, expand the existing VAMC clinic, limit the fee program to the Virgin Islands, and construct a 120-bed nursing home facility.

The Committee notes that, although it was expressly stated in the explanatory statement on the passage of Public Law 97-251 that the VA was to develop a comprehensive plan for providing health care for veterans in Puerto Rico and the Virgin Islands with needed projects prepared for inclusion in the President's fiscal year 1984 budget, the Administrator issued a disclaimer stating that the report "reflects a plan, but that the plan is not a recommendation and should not be construed as such". In addition, the report stated that it does not "constitute a requirement for funding or for any other legislative action, nor does it necessarily represent the views of the agency or of the Administration". On March 9, 1983, in testimony before the Committee, the VA's Chief Medical Director, Dr. Donald L. Custis, stated:

Regrettably, the complexity and timing of the Committees' request for this report did not permit the recommendations of this plan to be considered as part of the fiscal year 1984 budget process. Absent from the plan is the vital role of carefully considering the appropriate balance of the needs of our veterans in Puerto Rico and the Virgin Islands in relation to the needs of our veterans in all other parts of the United States.

#### *Committee Bill Provisions*

The Committee has rejected the 3-year extension proposed by the Administration in S. 664, introduced by request by the Chairman, and instead has reluctantly agreed, in section 108 of the Committee bill, to extend for 1 year until September 30, 1984, the authority for contract care for veterans in Puerto Rico and the Virgin Islands. The Committee believes that such extension is warranted to ensure continuity of medical care for certain veterans in Puerto Rico and the Virgin Islands during the time required by the Administrator to develop a report containing the plans of the Administrator, and the reasons therefor, for meeting the health-care needs of veterans in the Commonwealth of Puerto Rico and the Virgin Islands. In order that previous efforts to address this problem receive full consideration, section 108(b) of the Committee bill specifically requires that the VA submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives by December 1, 1983, a final report with its recommendation, and that the VA's recommen-

dations take into account the recommendations of the VA's Office of Inspector General (IG) which are contained in its "Report of Special Audit, VA Medical and Regional Office Center (VAMROC), San Juan, Puerto Rico" (Report No. 3R2-A05-043), dated February 22, 1983. The Committee believes that the VA's follow-up on the recommendations of the IG report has a direct bearing on the proper assessment of, and the scope of solutions to, health-care needs in Puerto Rico.

This report of special audit was completed at the request of the Chairman of the Subcommittee on Hospitals and Health Care of the House Veterans' Affairs Committee to evaluate the VA's management of its compensation program and to review instances of 100-percent service-connected disability claims in Puerto Rico and the use of contract psychiatric beds. The review focused on three issues and made the following findings and recommendations for action which the Committee believes raise some questions requiring prompt and thorough evaluation by the Administrator: That the Chief Benefits Director and the Chief Medical Director jointly review factors contributing to the statistically abnormal number of service-connected psychiatric claims and awards in Puerto Rico; that psychiatric patients in Puerto Rico in contract care facilities receive the same contract care assessment and monitoring procedures as do all other VA psychiatric patients; and that the monitoring of hospital service contracts be improved.

The Committee emphasizes that the major problems in Puerto Rico pointed out by the IG must be very seriously evaluated and addressed by the VA. The Committee bill requires that the required report take fully into account the VA's actions arising out of the IG's findings and recommendations and that VA responses to them be described fully in the required report to Congress.

The Committee reiterates its intent that the plan be prepared in the context of achieving an appropriate balance of health-care needs for all veterans and that if the plan developed by the Administration and included in the report required by section 108 of the Committee bill includes any construction projects, and if such construction project would require a prospectus under existing section 5004(b) of title 38, each construction project and its accompanying prospectus be included in such plan and report.

### *Resource Realignment*

Section 109 of the Committee bill, which is derived from title III of S. 578 as introduced, would provide for the realignment of VA health-care resources by requiring that at least \$20 million be added to the President's fiscal year 1984 budget for the provision of certain health-care services to eligible veterans and that the budget for beneficiary travel reimbursement payments be reduced by the same amount. Under section 109, the Administrator would be required to prescribe regulations in order to effectuate the realignment, in the VA medical care account, of funds obligated for making reimbursements to certain VA health-care beneficiaries for expenses of travel to and from VA facilities—so called "beneficiary travel"—under section 111 of title 38. Such regulations would provide criteria to ensure that not more than \$71,209,000 (\$20 million

less than the President's fiscal year 1984 budget request for beneficiary travel) may be obligated for fiscal year 1984 for beneficiary travel, but could not limit reimbursements to those receiving care for or in connection with service-connected disabilities.

This realignment would be required to result in not less than \$20 million being made available for fiscal year 1984 for the provision of adult day health care and community nursing home care to eligible veterans under section 620 of title 38, United States Code (as amended by section 101 of the Committee bill) and for the provision of preventive health-care services under sections 610 and 612, as defined under section 662 of such title (as amended by section 104 of the bill), and under the preventive services pilot program under subchapter VII of chapter 17 (also as amended by section 104 of the bill). If the Administrator determines that more than \$20 million will be made available as a result of regulations prescribed under this provision, such additional sums will be obligated for the same care and services or other authorized VA health-care activities designed to avoid the need for, or to shorten periods of, institutionalization of veterans such as hospital-based home care.

The Committee has noted on numerous occasions that the rapidly growing population of elderly veterans is expected to place a substantial burden on the capacity of the VA to continue to furnish quality health care. This population is anticipated to present an increased demand for acute care with more frequent and longer inpatient episodes, as well as an increased need for extended-care services and for use of outpatient services to treat chronic illnesses. The Committee believes that increased self-sufficiency, higher morale, and better health care could be expected to result by increasing resources available for non-institutional alternatives for treatment of elderly veterans. Stressing these alternatives would also allow for a relaxation of the burden on certain VA health-care facilities by reserving 24-hour per day nursing care for those who require such intense medical attention.

The Committee and the VA have long been concerned about beneficiary travel. In 1979, in Public Law 96-151, the Veterans' Health Programs Extension and Improvement Act of 1979, Congress amended section 111 for the purpose of specifically authorizing the Administrator to prescribe regulations to determine which veterans (not including veterans with service-connected disabilities, other persons receiving VA benefits in connection with service-connected disabilities, and persons who meet applicable income standards for VA pension eligibility) were unable to defray the cost of travel to and from VA health-care facilities. However, this authority remains unimplemented.

In 1980, the Committee noted that the VA had at that time taken some steps with regard to restricting beneficiary travel reimbursement by advising VA health-care facilities to regulate strictly reimbursements for such payments, to avoid costly modes of transportation (such as taxis and wheelchair vans), and to restrict the number of trips to health-care facilities to the extent consonant with the provision of good health care. (S. Rept. 96-747, 96th Cong., 2d Sess., p. 117.) The Committee encouraged the VA also to reduce the amount of funds required for beneficiary travel by planning new outpatient clinics and other health-care facilities with regard



to the needs of veteran populations which are situated remotely from existing VA health-care facilities. Id.

However, despite this encouragement, the VA did not until August 1982 publish proposed regulations under the 1979 authority relating to determinations of ability to pay, and has not yet issued final regulations. Meanwhile, the total cost of beneficiary travel burgeoned to \$81 million in fiscal year 1982 and is estimated to cost \$85.2 million in FY 1983. According to VA testimony at the March 9, 1983, hearing, "Our major concern is that by 1985, beneficiary travel could easily cost the Department of Medicine and Surgery under current rules \$100 million." According to VA testimony at this same hearing, station allocations of these funds are derived solely from each hospital's use of these funds in the previous year.

The Committee recognizes the importance of these travel benefits to veterans receiving care for or in connection with service-connected disabilities, and the Committee bill prohibits the new regulations from restricting payments to those veterans. The Committee intends that the VA, in developing the regulations, use its detailed knowledge of its health-care system and its primary missions, and expects the Administrator to take into account the special circumstances of veterans in Alaska and Hawaii, States where there are no VA hospitals and where the geography poses particular travel problems for many veterans.

In order for the Committee to monitor the implementation of section 109, the Committee bill would require the VA to submit to the House and Senate Committees on Veterans' Affairs certain reports containing information specified in that section about plans for and implementation of the realignment, including obligations on a monthly basis, and my revisions of plans. The Comptroller General, in consultation with the Director of the Congressional Budget Office, would be required to monitor the realignment and analyze the reports and to advise the committees of the results of their monitoring. If the realignment requirements are not met, as determined by the Comptroller General, then the beneficiary travel cap and the new regulation-prescribing authority would lose effect.

#### TITLE II—PROVISIONS TO IMPROVE THE RECRUITMENT AND RETENTION OF CERTAIN PERSONNEL

##### *Health-Care Personnel Provisions*

Title II of the Committee bill contains a number of provisions that are designed to improve the VA's ability to attract and retain various health-care personnel employed in the VA's Department of Medicine and Surgery (DM&S). The Committee noted in 1980 in connection with action on earlier legislation relating DM&S personnel issues:

Because a cadre of sufficient, qualified health-care personnel is the backbone of a strong VA health-care system, the Committee believes it is critical that the VA be able to attract and retain such personnel, including not just doctors but all health-care workers. (Committee report accompanying S. 2534, S. Rept. 96-747, 96th Cong. 2nd Sess., p. 33.)



The Committee remains convinced of the need to ensure that the VA is able to compete effectively with non-VA health-care employers for the services of qualified health-care personnel. The provisions of title II of the Committee bill are intended to support that goal. Without sufficient qualified personnel, DM&S, cannot be expected to fulfill its mission of providing quality health care to eligible veterans.

Because of concerns that the VA was experiencing significant recruitment and retention difficulties with respect to certain health-care occupations within DM&S, the Committee in 1980 developed legislation (in S. 2534), enacted as section 117 of Public Law 96-330, that directed the VA to conduct a study and report to the Congress on which of the categories of DM&S employees that provide direct patient-care services (or services incident to direct patient-care services) should be considered for conversion from the regular civil service personnel system under title 5, United States Code, to the special DM&S personnel system under title 38. The VA was also directed to make recommendations regarding existing personnel practices to deal with other recruitment and retention problems.

The report, prepared by a DM&S Task Force, in response to the Congressional mandate, entitled "Study of the Feasibility and Desirability of Converting Selected Health Care Occupations to Title 38, United States Code", was submitted to the Congress on September 1, 1982. This report well documented and comprehensive survey of the current situation regarding title 5 health-care personnel within DM&S, and contained many recommendations. The task force found that three health-care occupations in DM&S—certified or registered respiratory therapists, physical therapists, and licensed practical or vocational nurses—experience "severe difficulties in recruitment, retention, and morale on a nationwide basis" and recommended that they be converted to the title 38 personnel system.

#### *Need for Legislative Action With Respect to Three Occupations*

In response to the study recommendation relating to these three occupations, S. 11 as introduced included provisions to convert the occupations to title 38 with a modification to leave in effect certain title 5 provisions relating to employee probation periods, performance appraisals, and termination and disciplinary actions.

The Administration, represented by the Office of Personnel Management at a hearing held by the Committee on March 9, opposed the conversion provisions in S. 11. OPM expressed the view, both in prepared testimony and in response to followup questions, that the recruitment problems experienced by DM&S in the three occupations were not generally significant and could, in any event, be ameliorated within the existing OPM-administered civil service system. The Committee carefully considered OPM's position on this matter, that some more limited remedy would be appropriate as well as views expressed by other witnesses that the problems found by the task force are continuing. For example, in response to a written question regarding physical therapist vacancies in DM&S, the agency noted that, at the time of the task force study, there were "113 budgeted but vacant physical therapy positions" which represented 17 percent of the budgeted positions in the VA. The

VA then noted that a more recent survey indicated that there were "118 vacancies or 21 percent of the [VA's] 641 full-time positions." The VA also noted in that response that "the VA vacancy rate [for physical therapists] for the country as a whole is approximately double the national average." In response to another question regarding the effect of OPM efforts, through the approval of special salary rates, to remedy the VA's problems with recruiting and retaining physical therapists, the VA noted that these rates "have only had limited success" and that one problem with the OPM special rate process is that it "is very lengthy, often taking a year or more before approval is granted."

The Committee notes that the VA's Chief Medical Director, Dr. Donald Custis stated his personal, professional view on this issue during the March 9 hearing:

We have an acute need to acquire an ability to compete more effectively in the recruitment of certain disciplines, particularly these three.

Likewise, in response to a followup question, Dr. Custis indicated that nothing had happened to change his personal view, first expressed, in response to questions during the Committee's February 17 hearing on the VA's fiscal year 1984 budget, that the proposed conversions were "supported by the study" and "simply must be done if we are to compete with the private sector for these health disciplines." Dr. Custis had also noted at the earlier hearing that the three occupations "in particular are in short supply and availability to compete for their recruitment is getting weaker by the year."

Testimony received from each of the organizations representing individuals in the three occupations also supported the need for action to improve the VA's ability to compete for individuals in each of the occupations. Glen N. Gee, R.R.T., representing the American Association for Respiratory Therapy (AART), noted that "VA hospitals across the country are unable to hire and retain adequate numbers of qualified respiratory therapists and respiratory therapy technicians." To exemplify this statement, he compared the Loma Linda University Medical Center—which he testified has 544 beds, and 143 registered and registry-eligible therapists with the nearby Loma Linda VAMC, which has 600 beds with, according to the VA, 18 full-time and one part-time inhalation therapists of which two are registered and six are certified. R. Charles Harker, representing the American Physical Therapy Association, stated that "the attractiveness of working within the VA system is seriously diminished".

Paul Tendler, representing the National Federation of Licensed Practical Nurses, said "[s]adly, the present system of employment in the Veterans' Administration precludes [the recruitment and retention of qualified personnel]." In further elaboration on the situation facing licensed practical or vocational nurses, he noted:

The Veterans' Administration right now has a serious problem in the recruitment and retention of LP/VNs. In the 172 VA hospitals in the United States there are positions for approximately 9,600 LP/VNS. It should be noted

that this is the established ceiling and may not reflect the actual great need for the direct-care LP/VNs. At the end of 1982 over 900 of these positions were vacant. This was in spite of the fact that there are currently 27 areas where LP/VNs have been granted special pay rates. Note that since 1980, the health care occupations have accounted for almost 75 percent of OPM's special rates by locality. LP/VNs have these special rates in more locations than any other VA occupations.

After reviewing the various viewpoints and evaluating the task force's report, the Committee determined that legislative action is necessary to address the problems of recruitment and retention of the three specified occupations. In addition, as will be discussed below, there is also a need for improved administrative activity to address other difficulties DM&S is experiencing in recruiting and retaining sufficient personnel.

*Legislative Solution:* The Committee decided that a legislative solution to the recruitment and retention problems it found was necessary but not conversion of the three occupations to the title 38 personnel system. Instead, the Committee chose an approach which would leave the three occupations in title 5 but would give the Administrator new authorities as to these occupations for determining the qualifications of applicants, for appointing individuals to positions in DM&S, for advancing and promoting individuals, and for setting rates of pay including both basic pay and special pay for work outside of the regular workday or workweek.

The Committee adopted the approach in the Committee bill, described in more detail below, in response to a variety of concerns about the proposed conversion to title 38. The Committee's principal concerns in this regard centered on two attributes of employment under the title 38 system—the annual leave criteria and the prohibition against outside employment. There are significant differences in these two areas between the title 5 and title 38 systems, and the Committee had serious reservations about the economic implications of the proposed conversions on the VA and the employees insofar as these aspects were concerned, as well as about the advisability of across-the-board conversions that might not be best suited to dealing with a problem in a particular locale. Because of these concerns and because the particular problems identified with reference to the VA's ability to recruit and retain these three occupations could be addressed without removing the occupations from the title 5 personnel system, the Committee elected instead to make certain amendments in title 38 to give the Administrator significant new authorities to use in hiring individuals in the three occupations and in setting their rates of pay.

*Appointment Promotion Authority:* Specifically, under provisions in section 203 of the Committee bill, the Administrator would be given the authority to use the appointment authority in present section 4106(a) of title 38—under which the Administrator may determine qualifications for and make appointments to certain DM&S positions “without regard to civil-service requirements”—in connection with the hiring of certified or registered respiratory therapists, licensed physical therapists, and licensed practical or



vocational nurses. The basic difference in the appointment authority under the two systems is that under the title 38 appointment authority, the VA can take into consideration, in establishing criteria and pay rates, the level of training and education of the applicant. The use of the authority in present section 4106(c) for promoting and advancing individuals would also be given to the Administration. This authority is also more flexible than the comparable title 5 authority. Under this provision in the Committee bill, the Administrator would be required to apply the title 5 principles relating to veterans preference in the appointment of individuals to the three occupations in DM&S. It is the Committee's intent, by requiring application of veterans preference principles, that the Administrator, when applicants for a position are otherwise approximately equally qualified for a particular opening, will give the advantage to a veteran or other preference eligible and particularly so in the case of a veteran with a service-connected disability.

*Premium Pay Rates:* Provisions in section 204 of the Committee bill would provide the Administrator with new authorities for setting rates of pay for individuals in the three occupations. Specifically, the Administrator would be given the authority, under subsection (f) of present section 4107 of title 38, to pay individuals in the three occupations in DM&S premium pay for overtime, weekend, and other work outside of the regular work day or week on the same basis as such pay is paid to registered nurses under title 38. This authority, which could be exercised on whatever geographic basis the Administrator determines necessary, would be limited to situations where the Administrator determines its exercise is necessary for recruitment and retention purposes.

*Basic Pay Rates:* By virtue of other provisions in section 204 of the Committee bill, the Administrator would be authorized to use the authority in subsection (g) of present section 4107 to raise the rates of basic pay for individuals in the three occupations, again on whatever geographical basis is necessary and again when necessary for recruitment and retention purposes. Under current law, the Administrator has such authority but it is limited by a requirement that any proposed exercise of it be delayed for a 90-day period during which time the President could review the proposed increase and possibly disapprove it. This existing authority was first provided in Public Law 96-330 which was enacted in August 1980 but has yet to be used, in part apparently because of executive branch disagreement over how to implement the 90-day delay-and-review provision. The Committee bill would remove the applicability of this cumbersome provision to pay setting for these three occupations. The Committee views the new authority proposed in the Committee bill as an essential tool for the Administrator to meet the recruitment and retention problems in the three occupations and one which, in combination with the special appointment authority discussed above, should greatly enhance the VA's ability to compete effectively for individuals in the three occupations.

*Above-Entry-Level Appointment:* In addition to the provisions described above which are restricted to the three occupations, there is a provision in section 206 of the Committee bill which would apply both to individual appointments to these three occupations as well as to other DM&S positions providing direct patient-care services.



This provision would give the Administrator the authority, analogous to that in section 5333 of title 5 for positions above GS-11, to appoint an individual to a DM&S position at other than the minimum or entry rate for the grade involved. This authority would be available when appropriate in light of the individual's special qualifications or the existing pay that individual is receiving and which the VA must meet or exceed, or in light of special needs of the VA. This administrative authority should allow the Administrator to respond selectively to individual hiring situations in which a higher salary is warranted without having to make higher salary levels applicable across-the-board to a group of employees in the same job position.

### *Reports and Studies*

Because of the Committee's very strong interest in bringing about improvements in DM&S recruitment and retention, both through the prompt and effective utilization of the new authorities that would be provided by the provisions in the Committee bill and by other actions that do not appear to require legislation at this time, the Committee bill contains provisions that would require a joint VA-OPM report, a special 90-day implementation report from the VA, and a followup 2-year report from the VA on the effect on personnel problems of the use of various authorities, including the new authorities that would be provided by the Committee bill.

The joint VA-OPM report, which would be required to be submitted to the House and Senate Committees on Veterans' Affairs no later than January 1, 1984, would contain information on action taken by the VA in response to the recommendations from the Public Law 96-330 report, other than the recommendation for the statutory conversion to title 38 of the three occupations. Among those other recommendations, which do not appear to require legislative action at this point, are the following:

- The VA should issue implementing regulations to use section 112 of Public Law 96-330 (adding section 4107(g) to title 38, United States Code) to establish and approve competitive salary rates for six health-care occupations (heart-lung machine technicians, health technicians (ophthalmology), cardiac catheterization technicians, orthotists/prosthetists, hemodialysis technicians, and dental hygienists) in areas in which such rates are necessary to recruit and retain qualified candidates.
- The VA should negotiate delegations of authority (from OPM) to examine and certify candidates and establish a Special Examining Unit within the VA to identify quality candidates in a timely manner in six other DM&S occupations (clinical pharmacists, clinical dieticians, social workers, psychologists, occupational therapists, and audiology/speech pathologists).
- For seven other occupations (echocardiograph technicians, health technicians (ultrasound), therapeutic/diagnostic radiology technologists, nuclear medicine technicians, clinical microbiologists, medical/cytology technologists, and clinical chemists), the VA should use a combination of section 112 authorities (section 4107(g) of title 38) and some delegations of examining authority on a local basis.

The Committee believes that each of these recommendations has merit and should be given the most serious consideration by the VA and OPM. The requirement for a joint report is designed to bring the two agencies together in agreement on appropriate solutions and to elicit their combined and separate views as to whether significant difficulties occur in implementing some or all of these recommendations. This information will be useful to assist the Congress in considering whether further legislative action is necessary to bring about appropriate action on these recommendations.

The report on the implementation of the new authorities that would be provided by the various provisions in title II of the bill would be required to be submitted by the VA not later than 90 days after the date of the enactment of the legislation. The requirement for this report is a reflection of the Committee's strong interest in ensuring that the VA takes prompt and effective action to implement the new authorities. Part of the Committee's reason for requiring the implementation report stems from the delays, brought about by clearance requirements and lack of responsiveness within the Office of Management and Budget (OMB), and the Office of Personnel Management (OPM) in the implementation of personnel authorities enacted in Public Law 96-330 in August 1980 for which proposed regulations were not finally issued until January 1983 and then only after Congress last year in Public Law 97-251 required their issuance in that time frame. It is with the hope of avoiding similar delays in the implementation of the provisions of title II of the Committee bill and of securing the intended benefit to the provision of health care that a requirement for a prompt implementation report has been added. The Committee intends to give such a report immediate attention and, to the extent that any problems or delays are identified in the report, to act expeditiously to address any such problem or delays. It is the Committee's view that the implementation report should promote the timely coordination of efforts by the VA, OMB, and OPM in bringing about implementation of title II of the Committee bill in a timely manner.

The final report, which the VA would be required to submit no later than September 30, 1985, would focus on the effects of the use of the new authorities on the recruitment and retention of the DM&S personnel involved. The Committee views this report as a logical followup to the Public Law 96-330 section 117 report. Thus, the report should provide information on the problem areas identified in the earlier report, any changes in those areas, and an evaluation of the impact of the new authorities provided in title II of the Committee bill on DM&S personnel problems generally.

The Committee is aware that provisions in the Committee bill would have the effect of directly improving career opportunities for certain occupations in DM&S by giving the Administrator greater flexibility in terms of appointment and setting pay which should increase the attractiveness of the VA as a career for the occupations in question. In light of this, the VA would also be required by the Committee bill to include information in the report about other efforts—past, present, and planned—in DM&S to develop and carry out, under present section 4101(b) of title 38, programs of education and training for career advancement for nursing assistants, noncertified, nonregistered inhalation therapists, and other allied health-

care professionals employed in DM&S who provide either direct patient-care services or services incident to direct patient-care services. Section 4101(b) is designed to require the VA to develop these career opportunities and career ladders and to do so, if possible, in coordination and cooperation with those pertinent educational institutions that are willing to collaborate in this process or to do so directly if such collaboration is not forthcoming.

With particular reference to the nursing assistants and noncertified, nonregistered inhalation therapists, the Committee believes it is especially important that the VA have a planned and coordinated approach to promoting their career development in order to give them maximum opportunities to benefit from the improvements in VA career opportunities that will result for those in licensed practical or vocational nurse and certified or registered respiratory therapist positions, the positions for which individuals in these two occupations could be expected to become qualified after further training and experience. In this regards, the Committee notes the views expressed in the 1973 Committee report accompanying the legislation (S. 59 in the 93rd Congress) that set forth the current requirement in section 4101(b) of title 38 for career development, efforts in DM&S:

The reported bill also directs DM&S to provide for maximum opportunities for lateral mobility and career advancement for all its health care personnel, with particular emphasis upon continuing education and arrangements for obtaining academic credit for such on-job or in-job training. There is a particularly great need to open up career advancement and upgrade education opportunities for nursing assistants to be trained and advance to L.V.N.s., for L.V.N.s to move on to the increased responsibilities of the Registered Nurse, and for R.N.'s to be given special training to assume independent patient care responsibilities as nurse practitioners and physicians' and dentists' assistants [later redesignated expanded-function dental auxiliaries]. (S. Rept. No. 93-54, 93d Cong., 1st Sess., p. 27.)

The Committee believes this viewpoint is as valid now, 10 years later, as it was in 1973 and intends to review carefully the VA's report on its past, current, and future efforts in this regard.

#### TITLE III—WOMEN VETERANS

##### *Advisory Committee on Women Veterans*

Section 301 of the Committee bill, which is derived from section 201 of S. 11 as introduced, would require the Administrator to establish an Advisory Committee on Women Veterans that would have responsibility for evaluating VA programs, services, benefits, reports, and other activities as they relate to women veterans; to advise the Administrator on issues concerning women veterans; and to submit an annual report to the Congress on its views and findings.

The General Accounting Office in the September 24, 1982, GAO report, "Actions Needed to Insure that Female Veterans Have



Equal Access to VA Benefits" (GAO/HRD-82-98), concluded that because the VA's target population has been so predominantly male over the years, there are various shortcomings at present in the agency's efforts to meet the needs of women veterans. Testimony presented at Committee hearings on March 9 and 10, 1983, revealed there was general agreement among the Veterans' Administration, veterans' organizations, and others that the establishment of an advisory committee on women veterans to focus on this overall issue would be an appropriate action. The VA's prepared statement noted agency agreement "in principle with what appears to be the major purpose underlying [the provision to establish an Advisory Committee on Women Veterans]—the desirability of providing the Administrator a broad spectrum of views to assist the agency in planning to meet the needs of women veterans."

Support was voiced by witnesses representing the American Veterans Committee ("we think that having the congressional endorsement and the statutory requirement that such a committee be set up would add to the credibility of the work of the committee, it would add to its legitimacy, and it would convince women veterans that not only the VA but the Congress is interested in them"), the Vietnam Veterans of America ("We very strongly endorse the establishment of an advisory committee"), The American Legion ("supports the establishment of the Advisory Committee on Women with the VA"), the Veterans of Foreign Wars ("support the Advisory Committee on Women Veterans"), the Disabled American Veterans ("share the concerns . . . regarding the need for a legislated or a mandated advisory committee on women veterans"), and AMVETS ("we feel that the provision to establish the advisory committee on female veterans is long overdue").

In addition, both the witness representing the American Veterans Committee, Ms. June Willenz, AVC's Executive Director, and the witness representing the Vietnam Veterans of America, Ms. Lynda Van Devanter, VVA's National Women's Director, testified about the failure of their efforts to convince prior VA Administrators to establish an advisory committee on women veterans. Their experiences in this regard lend further support to the Committee's decision to establish the committee on a statutory basis so that the committee will assuredly survive the tenure of the incumbent Administrator who has demonstrated such support for this concept.

The VA, however, opposed the need to establish such an advisory committee as a statutory entity and stated that it would be sufficient for the Administrator to establish such a committee on an administrative basis, an effort which is already well underway. The VA witness testified:

We oppose this provision because we believe it unnecessarily restricts the Administrator's discretion to administer programs entrusted to his care and represents a mechanism which, in its rigidity, could actually prove a greater burden than a benefit. Moreover, it is unnecessary in light of the administrative actions already taken.

The Committee applauds the action taken by the current Administrator, Harry N. Walters, both on the overall issue of women veterans and the establishment, administratively, of an advisory com-



mittee. However, the Committee does not agree that the Administrator's laudable actions are a sufficient reason for the Committee not to support a statutory requirement for the establishment of an advisory committee. The Committee notes that similar arguments in opposition to a statutory advisory committee were put forward by the VA in 1981 concerning the establishment of an advisory committee on former prisoners of war. The Committee's response, in rejecting those arguments, as set forth in the Committee report accompanying S. 468 (S. Rept. No. 97-88, 97th Cong., 1st Sess., p. 17)—the legislation that ultimately became Public Law 97-37—is directly relevant to the issue of an advisory committee on women veterans:

The Committee believes that it is extremely important to take legislative action to insure that the advisory committee is established as an on-going committee with clear expectation and the responsibility of reporting to the Congress as well as the Veterans' Administration. . . .

By including the establishment of the advisory committee in the Committee bill, the Committee re-emphasizes its interest in such an advisory committee, and its desire to participate in the process of determining the configuration of the advisory committee, the formulation of its agenda and goals, and to receive its views on a regular basis.

The Committee has no less interest in issues relating to VA benefits for women veterans than it did when the issue was VA benefits for former prisoners of war.

The Committee stresses that another critical difference between a statutorily established and administratively established advisory committee is the extent to which the Congress receives pertinent information on a particular issue. In response to a followup question to the hearing testimony, the VA indicated that "advisory committees established administratively by the VA must report directly to the official of the Agency that establishes it" and that "[t]here is no indication, however, that the [Federal Advisory Committee Act] contemplated that advisory committees' findings, views, and recommendations should be furnished to Congress." It is precisely because the Committee believes that it should be kept apprised of the agency's efforts regarding women veterans and should have an independent basis for learning of matters related to this issue that may require administrative or legislative action that the Committee bill has included this provision to establish such an entity on a statutory basis. The Committee stresses that the provisions in section 301 of the Committee bill were specifically modified from those in section 201 of S. 11 as introduced, in response to concerns raised by the VA in testimony and responses to followup questions, to avoid establishing the advisory committee in such a way as would be unnecessarily restrictive. Specifically, the provision in the Committee bill was revised so that (1) the Administrator would be able to reappoint an individual to serve on the committee at the expiration of that individual's initial term; (2) the advisory committee's scope of inquiry would be broader (to include "outreach and other programs administered by the Veterans' Administration"); (3) the committee would be mandated to hold only

three meetings in fiscal year 1984 and not less than two per year thereafter (rather than four meetings in both fiscal years 1984 and 1985); and (4) the Administrator would have 30 days after receiving each of the advisory committee's reports before being required to submit them to the Congress (rather than having to submit such reports "immediately") during which 30-day period the Administrator could also prepare his views on the advisory committee's report and submit them concurrently.

Finally, with reference to the VA's concern that the statutory committee lacks a termination date, the Committee notes that if it should become clear that there is no continuing need for an advisory committee on women veterans, the Committee would consider the desirability of repeal of the statutory mandate.

#### *Fee-Basis Outpatient Care to Female Veterans for Gender-Related Conditions*

Section 302 of the Committee bill, which is derived from section 202 of S. 11, would authorize the Administrator to provide on a fee-for-services basis certain outpatient care for the nonservice-connected gender-specific disability of a woman veteran when the Veterans' Administration is unable to provide appropriate in-house care for her gender-related disability. This authority, which would allow the Administrator to also provide pre- or post-hospital care and care necessary to obviate the need for hospitalization, would expire on September 30, 1989. The Administrator would be required to make annual reports, at the time the President's budget is transmitted to the Congress, on the agency's use of this authority. These reports would include, as appropriate, a description on the agency's plans for the ensuing fiscal year, of the efforts underway in the fiscal year of the report, and of the activities undertaken in the prior fiscal year with respect to the use of the new authority. In addition, the Administrator would be required to submit, not later than September 30, 1988, to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report setting forth the Administrator's recommendation, and reasons therefor, on whether the authority should be extended beyond September 30, 1989, or be made permanent. In making this report to the Committees, the Administrator would be required to solicit and include the views of the Advisory Committee on Women Veterans (as proposed to be established by section 301 of the Committee bill) on the issue of the continuation of this authority.

The provision to establish the fee-basis authority was derived from a provision (introduced as section 2 of S. 2389 and later incorporated in S. 2385) that was reported on June 8, 1982, by the Committee during the last Congress (S. Rept. No. 97-467, 97th Cong., 2nd Sess.) and passed by the Senate on June 21, 1982. This provision was not included in the compromise measure developed with the Veterans' Affairs Committee of the House of Representatives and enacted as Public Law 97-251 because of a concern that providing the fee-bases authority could work at cross purposes with needed VA efforts to build up its in-house staff capacity to meet anticipated women veterans' gender-related needs in light of the growing number of women veterans in the Armed Forces.

However, shortly after the compromise legislation was passed, the General Accounting Office published a report (described above in the discussion of the Advisory Committee on Women Veterans) regarding the Veterans' Administration's efforts to provide medical benefits and services to women veterans. The GAO found that, because the Veterans' Administration's target population has been so predominantly male over the years, the agency was unable to meet the needs of many women veterans for gender-related health care. In light of these findings, the Committee has again considered and again recommended the fee-basis authority.

In approving this provision, the Committee intends only to ensure that women veterans have access to needed care during the period that the VA is working to develop its ability to meet the needs of women veterans for gender-related care, either through its in-house resources or through the coordinated, planned use of existing authorities to contract for (under section 4117 of title 38—authority to contract for scarce medical specialist services) or share health resources (under section 5053 of title 38—authority to enter into agreements for sharing specialized medical resources) and, in the interim, that the present situation under which male and female veterans do not have similar access to the type of care they each need should be corrected. The inclusion of the 1989 sunset provision, which was not part of the measure as passed by the Senate last year nor of the provision of S. 11 as introduced, reflects the Committee's intent that should there be no continuing need for this extraordinary authority beyond 1989 it should be allowed to lapse.

Commenting on the need for this authority during the Committee's March 10 hearing, the Deputy National Legislative Director of the Disabled American Veterans, Charles E. Joeckel, Jr., stated "(T)here is no doubt that female veterans do not have access to Veterans' Administration health care as do their male counterparts." Mr. Joeckel specifically stated that the DAV supported the enactment of the fee-basis provision as "a reasonable and necessary extension of current authority."

The Committee notes that, following issuance of the GAO report, the VA has taken some steps to remedy the problems identified by the GAO. In this regard, the VA's Chief Medical Director, Dr. Donald Custis, stated at the Committee's March 9 hearing:

The VA has made significant strides in improving our capability for treating women veterans, including the provision of outpatient care for gender-related disorders. Among those steps was the recent publication of a VA Circular (10-83-14)—Health Care for Female Veterans. The Circular—directed to our health care facilities—emphasizes the high priority which should be given to provision of health care services for female veterans.

The circular directs each medical center and outpatient clinic to review its method of providing outpatient gynecologic services. It further directs that those needing improvement upgrade this capability by June 1, 1983. The circular provides that in-house capability for providing the services is preferable, but that alternatives may include



the use of consultants as needed, or in regularly scheduled clinics, referral of women to other VA medical centers, and agreements with affiliated hospitals or DoD installations. This could include contracting for the services of gynecologists under the provisions of the sections 4117 or 5053 of title 38.

The Committee applauds this activity and trusts that in the near future the agency will be capable of meeting the health-care needs of women veterans. However, because it is not clear that all VA health-care facilities will have an established mechanism in place by June 1, 1983, the Committee believes the enactment of the proposed outpatient fee-basis authority for the treatment of gender-related conditions of women veterans is appropriate. Also, the Committee notes that, should the VA be able to routinely to provide needed treatment to women veterans, there will be no occasion to rely on the new fee-basis authority because that authority is only available, pursuant to section 601(4)(C) of title 38, United States Code, when VA-provided care is not available.

As a final point, the Committee notes its strong disagreement with the position expressed in the Veterans' Administration's prepared testimony submitted for the March 9 hearing. In opposing the enactment of this provision, the Veterans' Administration testimony stated: "Its enactment would thus run counter to the Administration's policy of ridding the U.S. Code of provisions which unjustifiably differentiate or effectively discriminate on the basis of sex." It is the Committee's view that rather than creating an unjustified discrimination on the basis of gender, the provision in the Committee bill would remedy an inequality in access to VA care. It may be that the differences in the access to VA care that the GAO described in its report are only the result of the historical makeup of the veteran population but it is clear that there has been a difference in such access and that it should be remedied.

#### TITLE IV.—PRESUMPTION CONCERNING DYSTHYMIC DISORDER

The legislative history of Public Law 97-37, the Former Prisoner of War Benefits Act of 1981, reflects the complex and technical nature of the issues faced by the Senate and House Committees when the Congress attempted to determine an appropriate legislative approach to providing additional presumptions under section 312 of title 38, United States Code, for certain mental disorders suffered by former prisoners of war. The proposed addition by the Committee bill of "dysthymic disorders (or depression neurosis)" to the list of presumptive diseases in section 312 is meant to give full effect to the intent of the Congress underlying Public Law 97-37.

The compromise agreement between the Senate and House Committees with respect to certain mental disabilities suffered by former POW's was described as follows in an explanatory statement entered into the Record in both Houses:

"[The Committees agreed to add] . . . any of the anxiety states (including post-traumatic stress neurosis), instead of psychoneuroses and psychophysiologic disorders, to the disorders to which the presumptions would apply. The Com-



mittees intend that the term "anxiety states" have the meaning prescribed under the heading "Anxiety States (or Anxiety Neuroses)" in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition), published by the American Psychiatric Association (pp. 230-239) and, in the event that a subsequent edition of that manual does not contain such a heading, the meaning that is provided in the subsequent edition for a category of disorders that the Administrator determines to be the corresponding category. (Congressional Record, July 30, 1981, p. S8909.)

The House bill, as well as several of the bills considered by the Senate Committee, would have added psychoneurosis as a presumptive disorder under section 312. However, the term "psychoneurosis" covers a wide variety of mental disorders, which include, but are not limited to, hypochondria, hysteria, phobia, depersonalization, and anxiety neurosis. The Senate Committee was concerned that this wide variety of disorders did not accurately reflect mental disorders often associated with internment.

The VA "Study of Former Prisoners of War", prepared pursuant to section 305 of Public Law 94-479 (Senate Committee Print No. 25, 96th Congress, 2nd Session) states that "anxiety neurosis" was the most prevalent service-connected mental disability among former POW's. In the review of the literature contained in the study, however, symptomatology of both anxiety and depression were found to have been described frequently in the research regarding POW's and other involuntary internees. In the VA study, considerable attention was given to exploring the similarities of the psychological effects of concentration camp and prisoner-of-war camp victims. The study notes that

"the two experiences can be classed as being of the same kind. As Segal points out: 'By common consensus, concentration camp survivors endured an experience unique in the annals of human history. Nevertheless, the behavioral consequences of concentration camp trauma can be seen as reflecting problems of readaption which all former prisoners share.' Baker supports this line of reasoning when he notes that 'Studies of prisoners held in military prisons or in concentration camps in World War II and onward to the present, have revealed an impact on health and behaviour from captivity which is relatively constant across nations, wars, and cultures.'" (p. 148).

Various names for sets of psychological symptoms of these two classes of victims have included "K-Z Syndrome" (so named from the German abbreviation for concentration camp) of which two very common symptoms are depression and apathy reported by Chodoff (1963), Krystal (1965), Haas (1965), Meerloo (1969) and Baker (1980); "Japanese POW Syndrome" reported by Brill (1946) and Brown (1949); and "apathy syndrome" or "Zombie reaction" reported by Strassman and Schein (1955) and Baker (1963). (The VA study contains complete citations for the research which is identified above by authors' last name and year of publication and for other studies.)

Depression is also noted in descriptions of associated features and differential diagnosis for three of the four distinct diagnostic categories of "anxiety states" in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition), (DSM-III), published by the American Psychiatric Association in 1980. (pp. 230-239). Specific to Post-Traumatic Stress Disorder, "Symptoms of depression and anxiety are common, and in some cases may be sufficiently severe to be diagnosed as an Anxiety or Depressive Disorder". (DSM-III, p. 237)

The Committee noted that VA guidelines for establishing service-connection for Post-Traumatic Stress Disorder were in draft form when Public Law 97-37 was being considered. Based on VA assurances that the guidelines were based on DSM-III, the Committee supported the VA administrative action. DVB Circular 21-81-9 was subsequently published with detailed reference to stresses listed in DSM-III as precipitants to Post-Traumatic Stress Disorder, stresses which are clearly like those stresses experienced by former POW's during their internment.

Thus, at the time of the agreement with the House Committee on Public Law 97-37, the Committee was not aware that there would be cases in which former POW's suffering from nonpsychotic depressive disorders would not be diagnosed as suffering from Post-Traumatic Stress Disorder and, therefore, not adjudged under the VA guidelines to be service-connected disabled.

However, in reviewing the disposition of claims for benefits under chapter 11 of title 38 submitted by former POW's during the first 18 months after Public Law 97-37 was enacted, the Committee found an apparent inconsistency in the resolutions of claims which were decided solely on the issue of depression or a depression-related diagnosis. Since the Committee found that the VA generally had been fair and equitable in implementing the law, the Committee Chairman initiated on February 23, 1983, an exchange of letters with the VA to elucidate the depression issue. This correspondence, included below, revealed that existing laws and regulations did not yield consistent claims results. In addition, a VA response to a letter from the Disabled American Veterans explicitly stated that only conditions categorized as anxiety in DSM-III are subject to a presumptive service-connection and that service-connection adjudications based on depressive neurosis "are clearly and unmistakably erroneous."

This information and supportive testimony during the Committee's March 9-10, 1983, hearings have prompted the Committee to propose the addition of "dysthymic disorder" or depressive neurosis as described in DSM-III, pages 220-223, as a presumptive basis for service-connected disabilities for former POW's. The Committee intends that this addition would correct the inadvertent oversight in the original legislation and establish a presumption for a mental disorder which is linked in scientific literature to the POW experience.

The correspondence on the depression issue, referenced above, follows:

U.S. SENATE  
OFFICE OF THE CLERK  
WASHINGTON, D.C. 20510  
TELEPHONE (202) 512-1000  
FACSIMILE (202) 512-1000  
MAIL ROOM (202) 512-1000  
RECORDS MANAGEMENT (202) 512-1000  
GENERAL INVESTIGATIVE DIVISION (202) 512-1000  
LEGISLATIVE COUNSEL (202) 512-1000  
OFFICE OF THE CHIEF OF STAFF (202) 512-1000  
OFFICE OF THE CLERK (202) 512-1000  
OFFICE OF THE CHIEF OF STAFF (202) 512-1000  
OFFICE OF THE CLERK (202) 512-1000

## United States Senate

COMMITTEE ON VETERANS' AFFAIRS  
WASHINGTON, D.C. 20510

February 2, 1983

Ms. Dorothy Starbuck  
Chief Benefits Director  
Veterans' Administration  
810 Vermont Avenue, N.W.  
Washington, D.C. 20420

Dear Dorothy:

I am writing to you to share some of my thoughts concerning the implementation of certain provisions of Public Law 97-37, The Former Prisoners of War Benefits Act of 1981. This legislation was meant to be a significant and appropriate expansion of benefits and services for a most worthy group of veterans -- those who had been held as prisoners of war while defending their country. I am interested in learning more about the VA's application of this law with respect to the claims of former prisoners of war who are seeking service-connected disability compensation benefits for certain mental disorders. I am particularly interested in the diagnosis of depression in former POW's as a factor used in determining ratings under the new law.

When this legislation was originally introduced, the Senate Committee recognized the need for some liberalization with respect to claims filed by former POW's for certain mental disorders. However, newly expanded guidelines for POW claims included specific instructions for the disposition of claims filed for Post-Traumatic Stress Disorder (PTSD), and it appeared to be more appropriate to allow the reopening of previously denied claims and to study the effect of the new guidelines on all POW claims (allowed and denied).

An important provision of P.L. 97-37 mandates that for not less than three years after the enactment of this law the Administrator maintain a centralized record of all claims of former POW's for disability compensation and of the disposition of such claims. This information was required to include, to the extent possible, a description of each disability claimed, the rating claimed, a statement as to whether the disability is claimed to be the result of the veteran's internment, and the disposition of the claim at each level of adjudication with respect to the issues of both service connection and degree of disability. The POW Advisory Committee was to be consulted on procedures for the establishment of this process and the Veterans' Affairs Committees were to receive a final report and recommendations at the end of the three-year period. This law also provided the Administrator with the authority to submit interim results when there was meaningful data to report.

It has been about a year and a half since the enactment of this law. I would ask that at this time you provide an interim report which would include the number of cases filed under the expanded presumption,

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the numbers allowed, disallowed, rationale for all such decisions, and the extent to which training has been given to adjudication officers, examining physicians and others who have responsibilities relating to the implementation of P.L. 97-37. It is important to me to be well-informed as to the appropriateness of this law, especially the provision which allows a presumption of service connection for former POW's who suffer from any of the anxiety states and the extent to which the VA has successfully implemented the changes mandated by P.L. 97-37.

At my direction, my staff has been attempting to follow the implementation of this law, and I would wish to point out that in the overall sense, it appears that the VA has been fair and equitable in this mission of providing health care and in the adjudication of claims dealing with the presumptive provisions established by P.L. 97-37.

In the House and Senate Veterans' Affairs Committees' compromise agreement on this legislation (which I have attached), the Committees agreed to "...adding any of the anxiety states (including post-traumatic stress neurosis)...to the disorders to which the presumption ... would apply." The Committees intended that the term "anxiety states" have the meaning prescribed under the heading Anxiety States (or Anxiety Neuroses) in the Diagnostic and Statistical Manual of Mental Disorders (Third Edition (DSM III)), published by the American Psychiatric Association (pp. 230-239).

Significantly, DVB Circular 21-81-9 points out that stressors mentioned in Section 309.81 of DSM III such as military combat, floods and earthquakes and actions with serious injuries such as vehicular or airplane crashes, large fires and certain other disasters such as shipwreck, bombing, torture and death camps are life threatening in nature and would evoke significant distress in most persons who were involved. The Circular goes on to mention that if any of these above-identified stressors or other life-threatening episodes had their onset during active duty, service connection may be established upon re-experiencing the traumatic event. It continues to underline that "(s)ome stressors frequently produce the disorder (PTSD) (e.g. torture) and others produce it only occasionally (e.g. car accidents)... The disorder is apparently more severe and longer lasting when the stressor is of human design."

By relating the provisions of the DVB Circular to Section 309.81 of the DSM III it appears clear that internment as a POW would be a stressor which could evoke significant symptoms of distress in most individuals. Under the heading "Associated Features" of PTSD, page 237 of DSM III the following is noted: Symptoms of depression and anxiety are common and in some instances may be sufficiently severe to be diagnosed as anxiety or a depressive disorder.

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As you know, the Committees intended to clearly define the categories to which the presumption of service connection for psychological impairment among former POW's would apply and specifically included Post-Traumatic Stress Disorders. I would appreciate your view as to whether the diagnosis of depression is a symptom of PTSD. My understanding is that the POW experience is a stressor as defined in Section 309.81 of DSM III, and indeed it was the intent of the Congress to encourage a more liberal interpretation of such POW cases based on DVB Circular 21-81-9 for a condition or feature associated with such a stressor.

In our examination of this matter, the Committee staff has reviewed 160 claims provided to them by the DAV. Among these claims, 19 cases were decided solely on the issue of depression or a depression-related diagnosis. I have attached these 19 cases for your information.

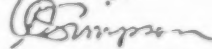
With respect to our review of these claims, I would note that of the 19 claims decided solely on the issue of service connection for varying diagnoses relating to depression, 11 claims were disallowed and 8 were granted. With the exception of one case, all VA decisions which granted service connection for depression contained an in-depth discussion of symptoms which in one way or another correlated the veteran's current condition with the POW experience.

On the other hand, of the 11 cases in which service connection was disallowed for depressive disorders, the reasons given for the denial varied dramatically even when the psychiatric impairment (depression) could be related to the veteran's captivity as a POW. In one of the cases, the rating board wrote "Service connection for the veteran's depressive reaction is not established. The diagnosis does not meet the standards for the Prisoner of War presumptive period established by DVB Circular 21-81-9". In another, while the veteran was diagnosed as suffering from dysthymic disorder, service connection for this condition and/or PTSD was disallowed.

With respect to the cases provided to the Committee by the DAV, in seven of the eight cases in which service connection was established, it appeared that the above-mentioned section of DSM III was used to justify the presumption. However, of the 11 cases diagnosed as depression which were denied, five opinions were based on the lack of such a presumption in P.L. 97-37.

Because I may wish to give further attention to this matter in the Committee's health hearing to be held in March, I would appreciate a timely response to my concerns to this very important matter affecting former POW's, all of whom made so many sacrifices and endured extreme hardships during their internment. We cannot forget their patriotism and wish to ensure that the legislation enacted on their behalf is well-designed and well-monitored so as to be responsive to their needs.

Sincerely,



BRIAN K. SIMPSON

Enclosures

cc: Harry W. Walters  
Everett Alvarez  
Donald L. Custis  
Lt. General John P. Flynn

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Office of the Chief  
Benefits Director

Washington, D.C. 20420



Veterans  
Administration

FEB 24 1983

Honorable Alan K. Siapason  
Chairman, Committee on Veterans' Affairs  
United States Senate  
Washington, DC 20510



Dear Mr. Chairman:

This is in response to your letter of February 2, 1983, concerning former prisoners of war and the handling of their claims of service-connection for depressive disorders.

In order to comply with the provisions of section 6(b) of Pub. L. No. 97-37, we have directed that copies of all rating decisions on claims made by former prisoners of war be referred to the Veterans Administration Central Office for recording and review. Ratings which appear to be inappropriate or not fully developed are returned to the regional office of jurisdiction for further consideration. Each rating decision is then recorded as to the disposition of all currently claimed disabilities. I am enclosing an interim summary as of January 3, 1983, showing the disposition of all POW claims received since enactment of the law. A more detailed report together with the views of the Advisory Committee on Former Prisoners of War will also be prepared and submitted as mandated by Pub. L. No. 97-37.

Training of rating specialists and others involved in the adjudication process initially took the form of circulars, program guides and regulatory amendments designed to communicate both the spirit and intent of the law. These directives were made an integral part of the training programs at all regional offices. At the suggestion of the Advisory Committee we produced a videotape designed to reinforce the information provided by directives and to sensitize employees to the POW experience. All regional office personnel are required to view this production. We are also currently engaged in a nationwide training program on rating practices and procedures. The correct method of handling the claims of former prisoners of war is one of the key items being presented. We will continue to assess the effectiveness of this training through statistical quality control and POW rating reviews by regional office senior supervisors and Central Office staff.

With regard to "depression", the word itself is more accurately a symptom than a diagnosis. Depression is a symptom of many mental disorders and is clearly an associated feature of post-traumatic stress disorder according

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to DSM-III. Rating boards are not, however, permitted to establish service-connection for a veteran's symptoms. It is the responsibility of the examining physician to evaluate a veteran's symptoms and clinical findings and report a valid diagnosis of the injury or disease entity responsible for the symptoms. If an examining physician makes a diagnosis of depressive neurosis or dysthymic disorder instead of post-traumatic stress disorder with associated features of depression, the rating board is bound by that diagnosis unless it can be questioned on the basis of insufficient findings.

Our review of POW rating decisions has resulted in approximately 150 referrals of cases back to the regional office of jurisdiction for corrective action or clarification of diagnosis. These cases have involved questionable grants as well as questionable denials of service-connection. Because the rating decisions attached to your letter did not show names and claim numbers, we are unable to determine if any of them have already been returned to regional offices for further consideration.

There is already a great deal of discussion within the medical community over the appropriateness of many sections in DSM-III. Resolution of these medical questions and publication of a fourth edition of the Diagnostic and Statistical Manual of Mental Disorders may go a long way toward resolving the problems of rating depression in POW cases. Until these issues are resolved, however, we must continue to accept established diagnoses and rate claims of service-connection in accordance with the law.

Please let me know if I can be of further assistance to you in this matter.

Sincerely yours,

  
DOROTHY L. STARBUCK  
Chief Benefits Director

Enclosure

## TITLE V.—STATUS AND ROLE OF ADMINISTRATOR OF VETERANS' AFFAIRS

Section 501 of the Committee bill would express the sense of the Congress that the Administrator of Veterans' Affairs should be designated a member of the President's Cabinet, should participate fully in Cabinet meetings, and should be the principal adviser to the President on all matters relating to veterans and their dependents.

This provision is derived from section 501 of s. 11 and the provisions of S. Con. Res. 2, which was also introduced on January 26.

For other 50 years, the Veterans' Administration has been the principal Federal agency with responsibility for providing benefits and services to veterans and their survivors. The agency's principal mission is described concisely and eloquently in the words of Abraham Lincoln in his second inaugural address—"to care for him who shall have borne the battle and for his widow, and his orphan." It is through the VA that the United States meets its historical commitment to provide health care and compensation to veterans disabled during their service, assistance to the survivors of those who made the ultimate sacrifice, and readjustment assistance to all those who served honorably in the Armed Forces during periods of war.

In addition, VA hospital and medical resources constitute the primary backup to the health-care resources of the Department of Defense in time of war or other national emergency involving military conflict. This important role of the Veterans' Administration was codified last year in Public Law 97-174. Should the need arise, the Veterans' Administration must be ready to provide critically needed assistance to DoD, the health-care resources of which would be totally inadequate to care for large numbers of battle casualties.

Today, there are nearly 29 million veterans and about 66 million dependents or survivors of veterans. Among Federal departments and agencies, only DoD has more employees than the Veterans' Administration, and the Veterans' Administration's proposed budget for fiscal year 1984—more than \$25 billion—ranks among the very largest Federal departments and agencies. The VA operates the largest centrally managed health-care system in the United States and administers the largest direct insurance program in the country. The Veterans' Administration will be distributing over \$13 billion in income maintenance payments and approximately \$1.7 billion in education, training, and rehabilitation assistance payments in fiscal year 1983. It administers one of the Federal Government's two major home loan guaranty programs, with over 4 million loans currently guaranteed; it operates 108 national cemeteries, and provides burial assistance in the case of nearly 350,000 deceased veterans annually.

Also, the Committee notes that under section 220 of title 38, United States Code, the Administrator has important statutory responsibilities for seeking to achieve the maximum feasible effectiveness and coordination of all Federal programs and activities affecting veterans—including those conducted by the Department of Labor and other agencies, as well as by the Veterans' Administration. The Administrator is also charged in that same provision with actively promoting the effective implementation and enforcement



of all laws and regulations providing for special consideration, emphasis, or preference for veterans.

In light of the Veterans' Administration's size and importance, and the responsibilities of the Administrator, the Committee attaches great importance to the recognition, status, and treatment that the agency and its programs are accorded within the executive branch. Cabinet status for the head of the Veterans' Administration would promote needed interaction with heads of executive branch departments, and would ensure that the Administrator would participate in top administration discussions and decision-making on issues having a direct affect on veterans.

In the past the Veterans' Administration has played a relatively insignificant role within the executive branch, with the Administrator at times having little or no access to the President or other top officials in the White House.

Under the previous Administration, the President conferred upon the Veterans' Administration the status of a Cabinet Agency, for the purpose of attending Cabinet meetings. In announcing that elevation in the Presidential Review Memorandum on Vietnam Era Veterans dated October 10, 1978, President Carter stated:

The Veterans' Administration is a large and important part of our government. Its presence at Cabinet meetings will be useful for other departments with overlapping responsibilities, and for the Veterans' Administration itself, which will have a stronger voice.

Despite its desire that the Administrator be made a full member of the Cabinet and the principal adviser to the President on all veterans matters, the Committee has not recommended a legislative mandate to that effect. Rather, in the interests of striking an appropriate balance between the prerogatives of the President and the Congress, the Committee bill contains an expression of the sense of the Congress that the Administrator should be designated a member of and full participant in the Cabinet and the President's principal adviser on veterans matters. The Cabinet consists of executive branch department heads and certain other officials designated by the President. Recognizing that neither the Cabinet nor its membership were established by the Congress, the Committee views a legislative mandate of a specific official's membership or participation in the Cabinet as an extraordinary remedy to be pursued only as a last resort.

#### TITLE VI—RADIATION EXPOSURE STUDY AND GUIDE

##### *Radiation Exposure Study and Guide and Government-Wide Coordination*

Section 601 of the Committee bill, derived from section 601 of S. 11, would require the VA to contract with an outside entity (other than the department of Defense or the Department of Energy) to conduct epidemiological study, except as such study is determined to be scientifically not feasible, of veterans exposed in service to radiation from nuclear detonations. This section would also require the VA to publish an indexed (desk-top) reference guide, derived from existing pertinent research compendiums, in order to provide

appropriate personnel with readily usable information regarding the state of medical and other scientific information on the long-term adverse health-effects in humans of exposure to ionizing radiation. Finally, this section would provide a process for promoting Government-wide coordination of research activities related to radiation exposure.

### *Background*

The Committee is concerned that the health status of service members potentially exposed to low levels of ionizing radiation from nuclear detonations has not been studied directly, and remains unknown.

The Committee received testimony on the provisions in the Committee bill on April 6, 1983, during its hearing on veterans' exposure to ionizing radiation. Witnesses revealed that approximately 250,000 service members participated in the U.S. nuclear test program prior to the signing of the Limited Test Ban Treaty in 1963. The best information available to the Committee indicates that another 130,000 participated in the occupation of Hiroshima or Nagasaki or transited those areas shortly after the detonations. It was evident from testimony that two issues regarding this population remain unresolved. First, exposure information for the veterans is far from complete. And, second, information about the health effects in humans of exposure to low-level ionizing radiation—the so-called “dose-response relationships”—is also incomplete, despite the over 80,000 studies conducted on the health effects of exposure to ionizing radiation and the growing body of knowledge based on the followup of the Japanese Hiroshima and Nagasaki survivors.

*Exposure information.*—The Committee heard testimony on the issue of exposure from several witnesses at the hearing. The Department of Defense (DOD) addressed the issue and reported that badge readings are available for 62 percent of the test participants but that the Hiroshima and Nagasaki occupation forces were not badged. DOD's Defense Nuclear Agency (DNA), therefore, has reconstructed exposures of more than 70,000 individuals based on existing records of the tests. However, testimony by the National Association of Atomic Veterans (NAAV) and the National Veterans Law Center emphasized that exposure to other types of radiation (specifically alpha, beta, and neutron) were not measured due to technical limits of the badges in the use at the time of these veterans' exposure. Lewis Milford of the National Veterans' Law Center observed that “the DNA essentially does not attempt to reconstruct inhaled or ingested radiation.”

Mr. Seymour Jablon of the National Academy of Sciences (NAS), in response to written questions in connection with the hearing, further pointed out that estimates of radiation dose should always be specific to the type of radiation and that the exposures should be calculated in dose-equivalents, or rems. With respect to certain types of radiation not measured by the badges, he stated that each neutron rad should be counted as worth 10 rems, and each alpha particle rad, as worth 20 rems.<sup>1</sup> (One rad of gamma radiation is

<sup>1</sup> A “rem”, an abbreviation for roentgen equivalent man, is a unit of radiation exposure measurement which reflects the amount of biological effect done by a particular form of radiation.

roughly equivalent to one rems.) Thus, it appears to the Committee that exposures with the greatest potential for causing adverse health effects were not recorded and have not yet been assessed as part of the massive reconstruction effort being carried out by DNA.

On this point, the DNA witness testified, "We have . . . analyzed internal exposure whenever investigation of exposure conditions for a given test indicated potential for internal dose . . . . The results of these analyses should be available by the end of the year."

*Dose-response relationship.*—Scientific witnesses discussed issues pertaining to radiation dose-response relationships in humans. On this subject, Mr. Seymour Jablon of the National Academy of Sciences stated:

I do not contend that radiation doses of one rad or even 100 millirads are harmless. I do say that it has never been possible to demonstrate harmful effects at such levels. It is prudent to assume that if large doses are clearly harmful, low doses may be also.

In addition, the Committee received testimony from Mr. Jablon and Dr. Edward P. Radford of the University of Pittsburgh, the former Chairman of the NAS Advisory Committee on Biological Effects of Ionizing Radiation (BEIR), which published the BEIR III report in 1980, who both indicated that ongoing reestimates of the doses received by the Japanese survivors were expected to alter current dose-response risk estimates by a factor of two—that is, a given radiation exposure will be considered to be twice as harmful as has heretofore been believed.

Dr. Glyn Caldwell from the Centers for Disease Control (CDC) presented testimony regarding his studies of the "Smoky" shot of the Plumbbob test series and the findings of an excess number of leukemia cases among the test participants. Dr. Caldwell reported that "[o]f deaths from leukemia . . . 9 were found compared to 3.1 expected. This difference is statistically significant". Ten cases of leukemia were observed where 4.0 would have been expected, he stated. He further reported that he had found an increased incidence of one other disease, polycythemia vera, which is characterized by an inappropriate increase in the number and production of red blood cells. Where 1 case was expected, 4 were found.

Mr. Jablon of the NAS testified that the CDC findings had "provided the impetus for an Academy study of the mortality experienced of just 50,000 participants in 5 test series, 2 at the Nevada Test Site and 3 in the Pacific Test area". He further reported that in the NAS study, still underway, "our first effort was to re-examine the situation for Smoky, since our methods are somewhat different from Dr. Caldwell's, to see if we got the same results, and essentially we did."

Mr. Jablon also reported that the excess of leukemias found in the Smoky population, which received a mean exposure of 456 millirems, according to the film badge data provided to Dr. Caldwell by the DOD, would have been expected in a population exposed to an average of 34 rads—more than 20 times the radiation indicated by the Smoky participants' badges. Dr. Caldwell acknowledged that in addition to the possibility that the Smoky participants' were in

fact exposed to a great deal more radiation than the film badges or reconstruction account for, there are other possible explanations for the Smoky results: (1) Radiation may be more harmful than previously believed; or (2) a different type of radiation exposure may have been present at Smoky than at other nuclear detonations, thus yielding an increased risk associated with exposure at shot Smoky.

Dr. Radford submitted testimony that newly published data from the Nagasaki tumor registry "indicates that lifetime risk of excess incident cancers is now about 1000 per million per rad, or ten times higher than the conventional wisdom."

### *Study*

In view of Dr. Caldwell's findings, the NAS replication of his findings with respect to leukemia, the uncertainties involving the levels of exposure received, and the recently reported information regarding the excess incidence of cancers in the Nagasaki survivors, and other uncertainties regarding dose-response relationships, the Committee believes that one final attempt to determine specifically the health status of exposed veterans should be made. The Committee recognizes the importance of a mortality study, such as the NAS study which Mr. Jablon described, for this purpose, but does not believe that a single effort focused on mortality alone is sufficient.

*Testimony regarding epidemiological study.*—The Committee heard testimony at the April 6 hearing on the study concept from five veterans organizations: The American Legion, the Disable American Veterans, the VFW, AMVETS, and the National Association of Atomic Veterans, all of which supported additional scientific study relating to veterans exposure to radiation.

Recognizing that scientific studies, such as section 601 of the Committee bill would provide for, are by nature very complex and that each study is likely to encounter problems specific to its mission, the Committee expressly sought expert opinion on the scientific feasibility of conducting such study. The major reservations expressed by witnesses with regard to conducting a morbidity study were associated, first, with the difficulty of locating individuals more than 20 years after exposure and, second, with the size of the population that should be studied in order to detect any excess adverse health effects.

Dr. Jablon outlined in some detail the logistical difficulties entailed in locating individuals who served in the military in the 1940's, 50's and 60's. He said:

The problem is that it was not until around 1957 that the military forces put social security numbers on military records, so [for] most of the veterans with whom we would be concerned, the social security numbers are not available. . . . Although military records contain enough identifying data to enable the Social Security Administration, in principle, to supply the Social Security number, this has not usually been very helpful in practice: The confidentiality provisions of the Social Security law have made it reluctant to supply information; and even more important,



to find the number even for a well-identified person requires a hand search through the many millions of the slips of paper which show number assignments. Such searches would probably be impractical, not to say very expensive, for any group larger than a few thousand names.

Thus, he concluded that "[a]t best morbidity studies of only a fraction of the exposed veterans would be feasible".

With respect to the required size of the study population, Mr. Jablon was asked the following question and provided the following answer in writing:

*Question:* Putting aside the practical difficulties of locating veterans who participated in atomic tests more than twenty years ago, what size and exposure level of the veteran population would be necessary for a morbidity study as outlined in the provisions of S. 11 to have, in your opinion, a reasonable possibility of producing useful information and detecting an excess of adverse health effects?

*Answer:* As a preliminary, the possible reasons for doing a study of morbidity are:

(1) To detect health effects which have little influence on mortality rates (e.g., thyroid nodules or thyroid cancer).

(2) To detect illnesses early so that treatment can be instituted.

To accomplish objective (2), continuing examination programs—annual or biennial—would be required; since only a single survey is proposed, it must find justification in the first reason listed.

The principal non-fatal effect to be sought would be thyroid cancer and thyroid nodules as representing possibly incipient cancer.

From NCI data the incidence of thyroid cancer in males between the ages of 40 to 64 varies between 3.8 and 4.8 per 100,000 annually.

According to BEIR 1980, the excess incidence of thyroid cancer in males is 2.2 cases per million per rad year. Thus, 1 rad produces 2.2 cases annually, and the natural incidence is 38 to 48 (both per million per year). Assume 20 years have passed since the end of the 10-year latent period; then 1,000,000 men have had about twenty million person-years with about 800 naturally occurring cases and 44 excess cases (for 1 rad). A comparison of 844 cases observed versus 800 expected in a so-called one-tail test would correspond to a probability of about .06, not quite significant.

If we imagine a study of 3,000 men, normal expectation would be 2.4 cases in 20 years at rates reported by NCI; to achieve statistical significance, 6 cases would have to be observed, or an excess of 3.6 cases. This would be produced by a dose of 27 rads to the thyroid gland at BEIR rates. Such a dose is implied by Dr. Caldwell's results, if the excess that he found at SMOKY is a real radiation effect, not a chance finding.

To \* \* \* answer then: Assuming the BEIR risk estimates to be low by a factor of 2 (so that the induction rate is really 4.4 per million year per rad), one would need: 3,000 men at 13.6

rads; 10,000 men at 6.8 rads; 20,000 men at 4.5 rads; 50,000 men at 2.7 rads.

The Defense Nuclear Agency testified at the Committee hearing that its scientists have identified 39 persons with exposure in excess of 25 rem, 1,111 with exposure between 5 and 25 rem and "[t]he average exposure to the overall group was half a rem per person \* \* \*."

Dr. Radford stated that, "the number of men exposed is large enough that it should be possible to detect effects even at relatively low doses." He added, however, that important considerations in undertaking such study would be whether many of these veterans could be traced, and whether, once located, uniform screening examinations could be accomplished.

In view of Mr. Jablon's and Dr. Radford's statements, the Committee assumes that, given DOD estimates of mean test participant exposures of approximately half a rem, the study under section 601(a) would have to be quite sizeable.

In addition to questions of purely scientific feasibility, the Committee notes that both Mr. Jablon and Dr. Radford stressed in connection with the hearing, that the possibility of very high cost was a factor to be considered in undertaking such study. Mr. Jablon stated, "I think that such a study would be very expensive, very difficult to accomplish and of dubious value." Dr. Radford reiterated this position saying, "I do not say that such a study would be impossible, but its potential usefulness in relation to the money spent would have to be carefully assessed before it should be undertaken." The Committee stresses, however, that questions of study cost and value, while pertinent to the determination of whether funds should be appropriated to carry out study to be conducted pursuant to the provision in the Committee bill, are not pertinent to any determinations made with respect to scientific feasibility.

Thus, the Committee considers very important the requirements contained in section 601(a)(3) and (4), respectively, of the Committee bill, that the Administrator include in certain reports to appropriate Congression Committees estimates of the expected cost of the protocol and study.

*Scientific Feasibility Assessment.*—In view of the complex nature and technical judgment involved in designing and conducting epidemiological study, the Committee believes that a careful and thorough scientific feasibility assessment should be carried out before the study is begun. In view of Dr. Radford's and Mr. Jablon's testimony and the Committee's experience regarding epidemiological studies, the Committee recognizes that the difficulties of such study are, in the words of one witness, "not to be underestimated" and has thus included a contingency provision in the Committee bill. Under that provision, if the Administrator determines that any portion of the study is not scientifically feasible, the Administrator would be required to notify the appropriate committees of the Congress promptly of this determination and of the reasons for it. If the Director of the Office of Technology Assessment (OTA) were to agree, that part of the study would not be required. If the Administrator determined that taken as a whole the study is not scientifically feasible and the OTA Director agreed, the entire statutory requirement for that study would lose effect.

*Study Design.*—In light of the very technical judgments that are involved, the Committee intends that the investigators conducting the study and those involved in determining the feasibility of such study be afforded maximum flexibility with respect to the study. Some of the witnesses made suggestions regarding various study constructs and recommended that portions of the scope of study provided for under the bill be carried out separately from others.

Mr. Jablon, for instance, suggested that, because the exposure levels of the atmospheric nuclear test participants was higher than the exposure levels of the Hiroshima and Nagasaki occupation forces, it would be wise to include only test participants in any studies conducted to detect increased incidence of adverse health effects which might be presented in the exposed veteran population. Both Mr. Jablon and Dr. Radford recommended separating any portion of the study dealing with birth defects in the exposed veterans' natural children from the rest of the study. Dr. Radford made an additional comment concerning studies which can best detect health effects in a population exposed to low-levels of radiation. He said:

We have good evidence that some of these long-term effects, such as benign nodules or cancers of the thyroid gland, as well as bone marrow cancers such as leukemia or multiple myeloma, should be detectable at low exposure doses if the populations are large enough. For purposes of surveying groups exposed at a few times background doses, we have considered that detection of solitary thyroid nodules or thyroid adenomas is the most practical approach to detecting late effects of low doses, though it is better for women than men.

The Committee values the opinions and suggestions of these and other scientists who have spent many years working in the fields of radiation effects and epidemiology. It recognizes that there are many scientific and practical considerations involved in embarking on this type of study and that other eminent scientists may offer other suggestions and considerations for approaching such study. Nevertheless, on balance, the Committee believes that the study should be pursued and carried out unless it is not scientifically feasible to do so.

*Report Requirements.*—Section 601 establishes a series of reporting requirements to ensure that the Congress and the public are periodically kept informed about the implementation of this provision and progress respecting study provided for under the bill. These reports are described in section-by-section analysis of subsections (a)(2)(A), (a)(2)(B), (a)(3), (a)(4), (a)(5), (a)(6), (b)(2), and (c)(2) of section 601 of the Committee bill.

*OTA Monitoring.*—Under section 601(a)(2), the Director of the Office of Technology Assessment would monitor the assessment of scientific feasibility, and, serving in a capacity similar to that which he serves in relation to the Agent Orange/Vietnam veterans epidemiological study mandated by section 307 of Public Law 96-151 as amended by Public Law 97-72, would monitor the development of the protocol for and the conduct of the study. Under section 601(a)(2), however, in order to avoid any questions of the Con-

stitutionality of the Director's role with respect to the study, the study design has not been made subject to the Director's veto.

### *Reference Guide*

Section 601(b) would require the VA to develop and publish for use by VA personnel—both those providing health care and those adjudicating radiation-related claims—a compilation or summary of the scientific literature concerning the long-term adverse health effects in humans of exposure to low-level ionizing radiation.

The Committee feels that the substantial benefit to be afforded by a convenient reference guide was clearly demonstrated at its April 6, 1983, hearing by responses to questions posed by the Committee. At that hearing, the VA confirmed that there are no internal VA guidelines for developing and adjudicating radiation-related claims—claims involving issues which can be very complex. The VA witness testified that a rating board physician can seek guidance regarding the relationship of specific diseases to radiation exposure by requesting published articles through the local VA medical center which has a hookup with the VA Central Office library. Additional guidance may be obtained by sending troublesome cases to Central Office for an opinion. The Committee finds that VA personnel do not have easy access to useful compilations or summaries of the scientific literature concerning health effects of exposure to low-level ionizing radiation and that an indexed reference guide for use by VA personnel would be a valuable tool—especially in light of the continuing backlog of cases before the VA—in assisting the Regional Offices and the Board of Veterans Appeals in taking into account when deciding radiation-related claims the most up-to-date medical and scientific information on the health effects of ionizing radiation.

To further illustrate this point, the case of a veteran test participant who died from chronic myeloid leukemia, which was raised at the hearing, revealed that the veteran presented a minimum exposure in excess of 7 rem, with credible evidence suggesting his exposure could have been 10 rem or more. However, the opinion of the VA Nuclear Medicine Service on the case had been, "there did not appear to be a cause and effect relationship between the veteran's participation in nuclear device testing and his death from leukemia, and it would be mere speculation to conclude otherwise". Mr. Jablon stated, however, that:

. . . the principal adverse health effects of low doses of ionizing radiation are the induction of leukemia, tumors and thyroid nodules. . . . Such effects actually have been demonstrated only following doses of at least 6 rads, but it is assumed that they also occur following lower doses.

This kind of example and the other testimony at the hearing demonstrated to the Committee the necessity of ensuring that VA personnel are kept informed of the most up-to-date medical and scientific information on the effects of exposure to ionizing radiation.

The Committee is aware that scientific inquiries on the biologic effects of exposure to radiation, and in particular the health effects in humans of such exposure, have been pursued for many years. In its January 2, 1981, report entitled "Problems in Assessing the



Cancer Risks of Low-level Ionizing Radiation Exposure" (EMD-81-1), the GAO pointed out that some 80,000 articles have been published internationally on the health effects of ionizing radiation. During the last 10 years, several reviews and summaries of this literature have been compiled. The most noted of these are the 1972 and 1980 reports of the Committee on Biologic Effects of Ionizing Radiation (BEIR) of the National Academy of Sciences and the 1977 report of the Scientific Committee on the Effects of Atomic Radiation of the United Nations (UNSCEAR). Testimony presented by Mr. Jablon revealed that the United Nations is preparing a new report to be released in 1985 or 1986. And Dr. Frank Press, the President of the NAS, in a response to a written question, reported that the NAS intends to update the BEIR report also by 1985 or 1986.

The Committee recognizes that these comprehensive reports have made a valuable contribution to knowledge related to radiation exposure, but believes that they vary in their utility for assisting the VA in the adjudication of cases involving radiation exposure from nuclear detonations since all of them are voluminous, include material on exposure resulting from numerous sources other than nuclear detonations, and were not designed to be ready reference sources. As Mr. Jablon testified: "[t]he reports are too voluminous. They discuss all of the qualifications that can be imagined, and you cannot expect a person—persons in the VA such as you described [adjudicators and health care providers]—to utilize them." Dr. Radford agreed. He stated that "[w]ith regard to a review and analysis of the literature concerning the health effects of ionizing radiation, I support such a project. The BEIR III and UNSCEAR 1977 reports are now obsolete, especially in view of the new data from the Japanese A-bomb survivors."

Therefore, the Committee bill would require the compilation of an indexed reference guide, in a form similar to the *Literature Review of Herbicides and Dioxins* produced as mandated by public Law 96-151. Such compilation or summary should be written in language which is reasonably familiar and accessible to all agency personnel who will be charged with its use, and should be issued in such quantities and kept in such locations as to ensure that it will be reasonably available to all such personnel for the use for which it is intended. By "indexed" the Committee intends that this guide be organized in such a way as to allow quick reference to literature specific to a given disease or condition and to provide access to such literature by the name of the investigator. The Committee further intends that the reference guide should be in a form such that it can and will periodically be updated, and the Committee bill requires periodic updating.

#### *Coordination of Government Activities*

Section 601(c) of the Committee bill would direct the President to ensure that such epidemiological study, as is mandated under the Committee bill, the development of the guide, and such additional research as may be identified are fully coordinated with studies or other activities pertaining to the adverse health effects in humans of exposure to radiation which are planned, ongoing, or completed by other entities in the Federal Government. This procedure is de-

signed to ensure that the VA is fully informed of, and gives all appropriate consideration to, the available relevant scientific information regarding human exposure to radiation, and that all Federal efforts in this area are efficiently conducted and coordinated.

Section 601(c) would also provide that, first, not later than 90 days after the date of enactment of the Committee bill, the President would be required to submit a report on the steps taken and the plans made to ensure that the required coordination with other Federal entities occurs; and, second, not later than 13 months after the date of enactment of the Committee bill, the VA would be required to submit a report on the literature review. This report would include comments and recommendations, for necessary administrative and legislative action, regarding the need for the VA or other Federal entities to conduct further research on the long-term adverse health effects of exposure to radiation. Further, the Administrator would be required to submit to such Federal entities with which the VA would be working, a copy of the report on the reference guide, and to recommend to those Federal entities, as appropriate, that they carry out such additional research as the report might indicate is needed.

#### FISCAL YEAR 1983 BUDGET IMPACT

The Committee intends that any fiscal year 1983 costs of implementing the provisions in the Committee bill for which no express authorization of appropriations is provided will be absorbed by the VA within existing resources. The Committee notes, on the basis of CBO cost estimates, that such costs are expected to be minimal.

#### COST ESTIMATE

In compliance with paragraph 11(a) of Rule, XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office, estimates that the costs resulting from the enactment of the Committee bill during the first 5 years following enactment would be \$21.7 million in fiscal year 1984; \$41.1 million in fiscal year 1985; \$42.4 million in fiscal year 1986; \$16.3 million in fiscal year 1987; and \$4.1 million in fiscal year 1988. A detailed breakdown of the costs, as estimated by CBO, over the 5-year period follows:

## CONGRESSIONAL BUDGET OFFICE

## COST ESTIMATE

May 16, 1983

1. BILL NUMBER: S. 578

2. BILL TITLE:

Veterans' Health Care and Programs Improvement Amendments of 1983

3. BILL STATUS:

As ordered reported by the Senate Committee on Veterans' Affairs, April 20, 1983.

4. BILL PURPOSE:

To provide for adult day health care and preventive health care for veterans, to establish an Advisory Committee on Women Veterans, to provide authority for fee-basis outpatient care for women veterans, to extend the authority to provide contract medical care in Puerto Rico and the Virgin Islands and to provide readjustment counseling services to Vietnam Era veterans, and for other purposes.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

(By fiscal year, in millions of dollars)

|                     | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> |
|---------------------|-------------|-------------|-------------|-------------|-------------|
| Authorization Level | 29.5        | 46.2        | 34.4        | 16.2        | 2.4         |
| Estimated Outlays   | 21.7        | 44.1        | 42.4        | 16.3        | 4.1         |

The cost of this bill would fall in budget function 700.

Basis of Estimate:

The following section-by-section cost analysis only addresses those provisions of S. 578 that would be expected to have a significant budgetary impact.

Title I

Sections 101, 104 and 109:

Section 101 would authorize a pilot program for the provision of adult day health care to enable certain veterans to reside at home rather than in a nursing home. The Veterans Administration (VA) would be given the authority to furnish such care under contract in non-VA facilities and to establish in-house programs in four VA hospitals or outpatient facilities. No such care could be provided after September 1987.

Section 104 relates to the authority currently in law permitting the VA to conduct a pilot program of preventive health care services for veterans. The VA has never implemented this pilot program. Title XI would make the pilot program mandatory in fiscal years 1984-1988 but would restrict eligibility to service-disabled veterans and those already receiving some form of medical care from the VA.

Section 109 would require the Administrator to promulgate regulations that would restrict payments for beneficiary travel to no more than \$71,209,000 in fiscal year 1984. This amount is exactly \$20 million less than the President's 1984 request budget for beneficiary travel. It would be left to the Administrator's discretion whether or not the regulations restricting beneficiary travel payments would remain in effect after September 30, 1984. Title III further provides that, of the amount appropriated to the Medical Care account for 1984, not less than \$20 million would be made available for the pilot programs established by Titles I and XI and for nursing home care, over and above the amounts requested for these activities in the President's budget.

(By fiscal year, in millions of dollars)

|                               | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> |
|-------------------------------|-------------|-------------|-------------|-------------|-------------|
| <u>Beneficiary Travel</u>     |             |             |             |             |             |
| Estimated Authorization Level | -20.0       | -20.9       | -21.9       | -22.9       | -23.8       |
| Estimated Outlays             | -18.0       | -20.8       | -21.8       | -22.8       | -23.7       |
| <u>Adult Day Health Care</u>  |             |             |             |             |             |
| Estimated Authorization Level | 5.0         | 10.4        | 11.0        | 11.4        | 0.0         |
| Estimated Outlays             | 4.0         | 10.0        | 11.1        | 11.4        | 1.3         |
| <u>Preventive Health Care</u> |             |             |             |             |             |
| Estimated Authorization Level | 5.0         | 10.5        | 15.0        | 15.0        | 15.0        |
| Estimated Outlays             | 4.0         | 9.9         | 15.1        | 15.0        | 15.0        |
| <u>Nursing Home Care</u>      |             |             |             |             |             |
| Estimated Authorization Level | 10.0        | 0.0         | 0.0         | 0.0         | 0.0         |
| Estimated Outlays             | 9.0         | 0.1         | 0.0         | 0.0         | 0.0         |
| <u>Net Budgetary Impact</u>   |             |             |             |             |             |
| Estimated Authorization Level | 0.0         | 0.0         | 4.1         | 3.5         | -8.8        |
| Estimated Outlays             | -1.0        | -0.8        | 4.4         | 3.6         | -7.4        |

According to information from the staff of the Senate Committee on Veterans' Affairs, it is the Committee's intention in these three titles to reallocate \$20 million of the funds requested by the President for beneficiary travel to pay for pilot programs in adult day health care and preventive health care. However, Titles I, III, and IX provide the Administrator with considerable latitude in the manner of their implementation. The VA has not yet determined what the agency's response would be to enactment of this legislation. However, based on informal discussions with VA staff, the following policy decisions were assumed on the part of the agency for the purpose of the estimate shown above:



- o The regulations restricting the amount of beneficiary travel payments would remain in force after fiscal year 1984.
- o These regulations would be written in such a manner so as to eliminate certain categories of current eligibles, thus resulting in savings that would increase over time with inflation. (Alternatively, it could have been assumed that VA would apply a flat cap on expenditures at the \$71,209,000 level. This approach would result in higher outyear savings, since the cap would not accommodate any inflation or program growth. It was felt, however, that the VA would be unlikely to take this course of action, because it could result in the denial of benefits to some service-disabled veterans.)
- o Delays in initiating the pilot programs for adult day health care and preventive health care would restrict the potential 1984 expenditures for these programs to one-half of the total Title III requirement for 1984 obligations. The remaining obligations would, as specified by Title III, be used for nursing home care.
- o The adult day health care pilot program would be continued up to its termination date of September 1987.
- o The preventive health care pilot program would be implemented to the maximum extent possible within its \$15 million statutory ceiling.
- o No additional funds would be made available for nursing home care after 1984 as a result of the enactment of this legislation.

Should the VA implement these titles through a different set of policies than assumed above, the budgetary impact of these provisions could be significantly different from that estimated.

Section 102: This section would extend for one year the period during which a Vietnam veteran may apply for psychological readjustment counseling.

(By fiscal year, in millions of dollars)

|                               | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> |
|-------------------------------|-------------|-------------|-------------|-------------|-------------|
| Estimated Authorization Level | 0.0         | 34.4        | 18.0        | 0.0         | 0.0         |
| Estimated Outlays             | 0.0         | 27.5        | 24.9        | 0.0         | 0.0         |

Because this section does not authorize the appropriation of specific amounts, it was assumed that the fiscal year 1983 appropriation level, as increased by anticipated inflation, would be appropriated in 1985. One-half of the corresponding amount for 1986 was assumed to be appropriated in that year to cover the cost for those veterans who apply for counseling before the delimiting date but whose treatment continues into the following year. Outlays were projected according to historical spending patterns.

Section 103: This section would require the Administrator to conduct a comprehensive study of the readjustment of Vietnam era veterans to civilian life. The study is specified to include a survey of the prevalence and incidence of post-traumatic stress disorder and related readjustment problems.

(By fiscal year, in millions of dollars)

|                               | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> |
|-------------------------------|-------------|-------------|-------------|-------------|-------------|
| Estimated Authorization Level | 3.0         | 0.0         | 0.0         | 0.0         | 0.0         |
| Estimated Outlays             | 0.5         | 1.7         | 0.8         | 0.0         | 0.0         |

Although language is not included in this provision to authorize a specific appropriation amount for the conduct of this study, it was assumed that the existing language would be sufficient to authorize the appropriation of such sums as may be necessary. The cost of this study would depend on the manner in which it is conducted, whether it is done in-house or under contract, the size of the surveys involved, and a number of other factors that could only be determined by the agency. The above estimate is based on the cost of other recent studies performed by the VA, but should be viewed as a rough magnitude estimate only.

Section 105: This section would authorize the VA to provide on a fee basis chiropractic services to eligible veterans for neuromusculoskeletal conditions of the spine. Total expenditures for chiropractic services would be limited to a maximum of \$2 million per year, and no payments could be made for services furnished after September 1987.

(By fiscal year, in millions of dollars)

|                               | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> |
|-------------------------------|-------------|-------------|-------------|-------------|-------------|
| Estimated Authorization Level | 2.0         | 2.0         | 2.0         | 2.0         | 0.0         |
| Estimated Outlays             | 1.7         | 2.0         | 2.0         | 2.0         | 0.3         |

It is estimated, based on VA information, that there would be sufficient demand for chiropractic services from eligible veterans to generate expenditures at the maximum level allowed for this provision. Outlays were estimated according to spending patterns typical of reimbursement programs.

Section 107: This section would increase the per diem rate payable by the VA to states providing domiciliary, nursing home, and hospital care to veterans in state homes. The increase would take effect on April 1, 1984, if adequate funds are specifically appropriated for this purpose. Otherwise, the increase would become effective on September 1, 1984.

(By fiscal year, in millions of dollars)

|                               | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> |
|-------------------------------|-------------|-------------|-------------|-------------|-------------|
| Estimated Authorization Level | 3.5         | 7.3         | 7.6         | 7.9         | 8.3         |
| Estimated Outlays             | 3.5         | 7.3         | 7.6         | 7.9         | 8.3         |

The above estimate assumes full appropriation of the authorized rate increase.

State Domiciliaries and Nursing Homes: Because the average length of stay for veterans in these facilities exceeds 365 days, a projected average daily census was used as the indicator of the number of veterans on whose behalf state facilities would be reimbursed. In fiscal year 1982 the average daily census of veterans in state domiciliaries was 4,493 and in state nursing home 6,428. Based on historical trends, the level in domiciliaries is anticipated to decrease to about 3,750 by 1988, while the level in nursing homes should rise to around 9,650. The projected average daily census in each type of facility was multiplied by the proposed increase in per diem rates for 365 days.

State Hospitals: The average length of stay for veterans in state hospitals in fiscal year 1982 was 72.3 days. A projection of the average length of stay was multiplied by the projected number of veteran patients treated in each year to calculate the number of reimbursable patient days per year. This, in turn, was multiplied by the proposed increase in the per diem rate for veterans in state hospitals.

Section 108: This section would extend for one year the authority to the VA to provide contract medical care to veterans in Puerto Rico and the Virgin Islands.

(By fiscal year, in millions of dollars)

|                               | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> |
|-------------------------------|-------------|-------------|-------------|-------------|-------------|
| Estimated Authorization Level | 17.6        | 0.0         | 0.0         | 0.0         | 0.0         |
| Estimated Outlays             | 14.1        | 3.5         | 0.0         | 0.0         | 0.0         |

The estimate shown above represents those amounts requested by the VA for fiscal year 1984 for the provision of contract medical care in Puerto Rico and the Virgin Islands.

## Title II

Section 201: This section would provide that three categories of medical personnel--respiratory therapists, licensed physical therapists, and licensed practical nurses--be placed under the authority of Title 38, U.S.C., rather than Title 5, for the purposes of pay and hiring only.

(By fiscal year, in millions of dollars)

|                               | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> |
|-------------------------------|-------------|-------------|-------------|-------------|-------------|
| Estimated Authorization Level | 2.4         | 2.5         | 2.7         | 2.8         | 2.9         |
| Estimated Outlays             | 2.3         | 2.5         | 2.7         | 2.8         | 2.9         |

This provision would allow the VA to hire personnel in these job categories at higher starting salary levels than is permitted under the regulations of the Office of Personnel Management (OPM). These job categories would also be made eligible for the additional pay; e.g., Saturday premium pay, night differential pay; currently authorized for registered nurses. According to information from the VA, the agency would be unlikely to make much use of the additional pay authority, because such types of incentives are rarely used for these job categories in the private sector. It is expected that the agency would utilize the hiring authority extensively. However, the cost of hiring at higher starting salaries would be largely offset by a reduction in the need for VA to increase entire salary structures in certain geographical areas in order to compete with private sector pay scales. (Under current law, VA has the authority to increase the entire salary scale for a certain job category in a particular geographical area in order to meet the hiring competition from non-federal medical facilities. It has often been necessary to use this approach to hire sufficient personnel in these job categories when the only portion of the salary scale that was not competitive was starting salaries.)

The 1984 cost of this provision is based on information received informally from the VA. Out-year costs are inflated by CBO assumptions of increases in federal pay.

## Title III

Section 302: This section would authorize the Administrator to provide fee-basis outpatient care to eligible women veterans for gender-related conditions.

Since women make up only 2.5 percent of the veteran population and only 1.75 percent of the VA hospital patient-load, it is not expected that this provision would result in a significant increase in medical care costs.



#### Title IV

This title would establish a presumption of service-connection for the condition of dysthymic disorder among veterans who are former prisoners of war (POWs).

According to the most recent estimates, there were fewer than 100,000 former POWs still living in 1979. Since a large proportion of these veterans are currently receiving compensation, it is not expected that this provision would generate a sufficient number of new cases to result in a significant increase in compensation costs.

#### Title VI

This title would provide for the conduct by the VA of an epidemiological study of the long-term adverse health effects of exposure to ionizing radiation from the detonation of a nuclear device. The title further provides, however, that, if such a study is determined to be unfeasible, the requirement would be repealed.

In addition, the Administrator would be required to develop and publish an indexed reference guide of available medical and other scientific information on the long-term adverse health effects of exposure to radiation. This guide would be distributed to VA medical and adjudication personnel, as well as any personnel in other federal agencies involved in related studies or research.

(By fiscal year, in millions of dollars)

|                               | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> |
|-------------------------------|-------------|-------------|-------------|-------------|-------------|
| Estimated Authorization Level | 1.0         | 0.0         | 0.0         | 0.0         | 0.0         |
| Estimated Outlays             | 0.6         | 0.4         | 0.0         | 0.0         | 0.0         |

In written testimony submitted to the Senate Committee on Veterans' Affairs, Edward P. Radford, M.D., Professor of Environmental Epidemiology at the University of Pittsburgh Graduate School of Public Health, and Seymour Jablon of the Medical Follow-up Agency of the National Research Council, both conclude that the value of an epidemiological study, such as authorized by this title, would be small in relation to the cost and difficulty of performing it. The above estimate, therefore, assumes that the study would not be found to be feasible.

The cost above relates to the development and, particularly, the printing and distribution of the reference guide. It assumes, based on information from VA sources, that the guide would be prepared under contract.

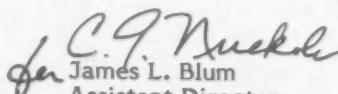
## 6. ESTIMATED COST TO STATE AND LOCAL GOVERNMENTS:

Section 107 of S. 578 would increase the per diem rate payable by the VA to states providing domiciliary, nursing home, and hospital care to veterans in state homes. These payments are designed to partially defray the cost to states of providing such care to veterans; however, in no case can the per diem payment exceed 50 percent of the actual cost of a veteran's care in a state home. The increase in the per diem rates would partially offset the inflation experienced by state homes in recent years in cost of providing care. Enactment of this provision would, therefore, result in the following estimated increase in revenues for those states operating state homes:

(By fiscal year, in millions of dollars)

|                | <u>1984</u> | <u>1985</u> | <u>1986</u> | <u>1987</u> | <u>1988</u> |
|----------------|-------------|-------------|-------------|-------------|-------------|
| State Revenues | 3.5         | 7.3         | 7.6         | 7.9         | 8.3         |

7. ESTIMATE COMPARISON: None
8. PREVIOUS CBO ESTIMATE: None
9. ESTIMATE PREPARED BY: K.W. Shepherd (226-2820)
10. ESTIMATE APPROVED BY:

  
 for James L. Blum  
 Assistant Director  
 for Budget Analysis

## REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact which would be incurred in carrying out the committee bill. The results of that evaluation are described below.

*A. Estimate of the number of individuals and businesses who would be regulated and a determination of the groups and classes of such individuals and businesses:*

The enactment of the Committee bill would result in the regulation of no individuals and only the provisions of section 101, which would authorize the VA to conduct a pilot adult day health-care program involving, in part, the agency entering into contracts with private entities pursuant to which eligible veterans would be provided certain services, and section 106, which would require the VA to issue regulations setting standards for community residential-care facilities which would apply to all facilities which desire to have the VA refer veterans to them, would arguably entail the regulation of any businesses. It is estimated that approximately 3,200 businesses—mostly small, often family-owned businesses—would be

affected by the regulations issued under section 106. It is not anticipated that the impact of these regulations will be substantial, however, as it would apply only to facilities which voluntarily seek VA referrals and the actual regulatory impact would be similar to that already imposed on such entities as a result of State and local licensing authorities.

*B. Determination of the economic impact of such regulations on individuals, consumers, and the businesses affected:* As discussed above, the Committee does not anticipate that there will be any significant economic impact on individuals, consumers, or businesses as a result of the enactment of any of the provisions of the Committee bill.

*C. Determination of the impact on the personal privacy of the individual affected:* The enactment of the bill would have no significant impact on the personal privacy of any persons.

*D. Determination of the amount of additional paperwork that will result from regulations to be promulgated under the bill:* None of the provisions of the bill entail regulations that would impose significant new paperwork requirements on individuals or businesses.

#### SECTION-BY-SECTION ANALYSIS OF S. 578 AS REPORTED

##### Section 1—SHORT TITLE

*Subsection (a) of section 1* would provide that the Committee bill may be cited as the "Veterans' Health Care and Programs Improvement Act of 1983".

*Subsection (b) of section 1* would provide that, whenever in the Committee bill an amendment or repeal is expressed in terms of an amendment or repeal of a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code, relating to veterans' benefits and services.

#### TITLE I—VETERANS' ADMINISTRATION HEALTH CARE PROGRAMS

##### Section 101

Would amend present section 620 of title 38, United States Code, relating to providing eligible veterans with nursing home care in community (non-VA) facilities at VA expense, to authorize an approximately four-year pilot program of adult day health care, generally to be provided in non-VA facilities, as a noninstitutional, alternative form of care for veterans who are eligible for nursing home care at VA expense in community facilities.

*Clause (1) of subsection (a) of section 101* would amend the catchline of present section 620 to add "adult day health-care pilot program", thus reflecting the addition of provisions (as proposed by subsection (a)(4) and (5) of this section of the Committee bill) to authorize the conduct of such a program.

*Clause (2) of subsection (a) of section 101* would make a technical amendment to a reference in present section 620(a) to a non-VA institution as an "institution not under the jurisdiction of the Administrator" so as to refer to the "direct" jurisdiction of the Adminis-

trator. This phraseology conforms to other such references in this subsection and elsewhere in title 38.

*Clause (3) of subsection (a) of section 101* would amend subsection (b) of present section 620, relating to VA standards for community nursing homes to which veterans are transferred or admitted for care at VA expense, to prohibit the transfer of a veteran to any institution for adult day health care (at VA expense) under section 620 unless the institution is determined to meet VA standards for non-VA adult day health care facilities.

*Clause (4) of subsection (a) of section 101* would amend subsection (e) of present section 620, relating to a definition of "nursing home care", to redesignate that subsection as paragraph (1) of subsection (f) and to add at the end of subsection (f), as proposed to be so redesignated, a new paragraph (2), as follows:

*New paragraph (2):* Would define the term "adult day health care" for purposes of section 620 as meaning health and social services furnished in a congregate setting during daytime hours for the purpose of enabling the individual to reside in a supportive home environment rather than in a nursing home. The health and social services involved include, but are not limited to, outpatient medical services (as defined in present section 601(6) of title 38), midday meals, and transportation (not limited by the requirements of present section 111 of title 38), including transportation between the individual's home and the facility.

*Clause (5) of subsection (a) of section 101* would amend present section 620 by inserting a new subsection (e), as follows:

*Subparagraph (a) of paragraph (1) of new subsection (e):* Would authorize the conduct of a pilot program of adult day health care under which veterans who meet the eligibility requirements, set forth in subsection (a) of section 620, for transfer to a community nursing home for care at VA expense, could be provided with adult day health care in non-VA facilities at VA expense. Under the eligibility requirements for transfer to a community nursing home for care at VA expense, which would be made applicable to transfers to non-VA adult day health-care facilities, the veteran must have been furnished hospital care in a VA facility, must have received maximum benefits from hospital care, and must be determined to require a protracted period of nursing home care.

As in the case of community nursing home care, adult day health care in a community facility would not be authorized at VA expense for a period of more than 6 months in the aggregate in connection with any one transfer unless either the veteran's hospitalization had been primarily for a service-connected disability or the Administrator determines that a longer period is warranted in the case of any other veteran.

A limited program of direct VA adult day health care would be authorized by paragraph (3) of new subsection (e).

*Subparagraph (B) of paragraph (1) of new subsection (e):* Would make applicable to the furnishing of adult day health care the terms and conditions established as to community nursing homes by subsections (b) and (c) of present section 620, relating to VA standards for community facilities providing care at VA expense and to the application of certain provisions of the Service Contract



Act of 1965 with respect to any contract for providing care to veterans under section 620, respectively.

In addition, the following section 620 authorities would be made expressly available with respect to the furnishing of adult day health care to veterans: the authority, in the final sentence of subsection (a), to furnish nursing home care in a community facility to veterans who were furnished hospital care by the VA in non-VA hospitals in Alaska and Hawaii and the authority, in the first two sentences of subsection (d), to provide for the direct admission of a veteran to a community nursing home for necessary care, as determined by a VA or (in specified circumstances) contract physician, for a service-connected disability.

*Subparagraph (C) of paragraph (1) of new subsection (e):* Would limit the authority to provide a veteran with adult day health care by allowing it to be exercised only where the Administrator determines that the weekly cost of the care would be less than the weekly cost of community nursing home care provided at VA expense and of direct VA nursing home care.

*Paragraph (2) of new subsection (e):* Would authorize the VA to enter into a contractual arrangement with a non-VA adult day health-care facility whereby the VA would provide the facility with in-kind assistance—for example, the temporary, part-time services of VA employees and the use of VA supplies and equipment—and receive appropriate reduction in the charges otherwise payable by the VA for the care of eligible veterans. In such an arrangement, the VA would be authorized to agree to provide in-kind assistance for use solely in the furnishing of adult day health care and only when the cost of such assistance is no more than the amount of the charges that the VA would be relieved of paying.

*Paragraph (3) of new subsection (e):* Would authorize, as part of the pilot program of adult day health care (which would be scheduled to expire at the end of fiscal year 1987), the VA itself to conduct adult day health-care programs at four geographically dispersed VA hospital or outpatient facilities. The same eligibility criteria (set forth in paragraph (1)(A) of the new subsection) as apply to a veteran's participation in the contract adult day health-care program would be made applicable to a veteran's eligibility for participation in a direct VA program.

*Paragraph (4) of new subsection (e):* Would require the VA, to the extent that it would carry out the adult day health-care pilot program, to plan and conduct the program and a study of it in such a way as to provide for the assessment and demonstration of (1) whatever efficacy and cost-effectiveness there may be in furnishing this form of day care as an alternative to nursing home care, and (2) the comparative advantages and disadvantages of providing adult day health care through non-VA and VA facilities; and would establish a September 30, 1987, termination date for the pilot program.

*Paragraph (5) new subsection (e):* Would require the VA to include, in each of its annual reports to the Congress for fiscal years 1984, 1985, and 1986, detailed descriptions of the activities carried out under this new subsection (e); and would require the Administrator, not later than December 1, 1986, to submit to the House and Senate Committees on Veterans' Affairs a report containing the re-

sults of any study conducted under paragraph (4) of this new subsection and any recommendations for legislative and administrative action that the Administrator considers appropriate.

*Subsection (b) of section 101* would amend the table of sections at the beginning of chapter 17 of title 38, relating to hospital, nursing home, domiciliary, and medical care, to reflect the amendment to the catchline of section 620 proposed to be made by subsection (a)(1) of this section of the Committee bill.

*Section 101—Costs:* Enactment of the provisions of section 101 is estimated to entail costs of \$4 million in fiscal year 1984. The costs of this provision in fiscal year 1984 would be offset by cost reductions made by provisions in section 109 of the Committee bill.

### *Section 102*

*Clause (1) of section 102* would amend present section 612a(a), relating to eligibility for readjustment counseling services for Vietnam-era veterans, to extend by one year—from September 30, 1984, to September 30, 1985—the date by which an otherwise eligible Vietnam-era veteran who has been discharged from military service for more than two years may request such readjustment counseling.

*Clause (2) of section 102* would amend present section 612A(g)(1), relating to the steps that the Administrator is required to take to ensure an orderly transition of the VA's readjustment counseling program from a program providing readjustment counseling primarily through centers situated apart from VA facilities that provide other health-care services to a program providing such counseling through such other VA health-care facilities, to extend by one year—from September 30, 1984, to September 30, 1985, and from October 1, 1984, to October 1, 1985—the dates by which such steps are to be taken and such transition is to be completed, respectively.

*Clause (3) of section 102* would amend present section 612A(g)(2) relating to a report that the Administrator must submit to the Committees on Veterans's Affairs of the House of Representatives and the Senate on the Administrator's plans to carry out the requirements of section 612A(g)(1) (discussed above in the analysis of clause (2) of this section of the Committee bill), to delay the deadline for the report by 6 months—from April 1, 1984, to October 1, 1984—and to expand the subject matter of the report to include the Administrator's evaluation of the effectiveness of the VA's readjustment counseling services in meeting the readjustment needs of Vietnam-era veterans, with particular reference to the identification and treatment of post-traumatic stress disorder.

*Section 102—Costs:* Enactment of the provisions of section 102 is estimated to entail no costs in fiscal year 1984.

### *Section 103*

Would require the Administrator to conduct a comprehensive study of post-traumatic stress disorder and related problems in readjusting to civilian life among Vietnam-era veterans and to report to the Congress on the results of the study.

*Subsection (a) of section 103* would require the Administrator to design and conduct a comprehensive study of the prevalence, inci-

dence, and effects of post-traumatic stress disorder and related problems in readjusting to civilian life among Vietnam-era veterans, with particular emphasis on those with service-connected disabilities and those who served in Vietnam or in the Vietnam theater of operations and with specific reference to women Vietnam-era veterans.

*Subsection (b) of section 103* would require the Administrator to submit a report, not later than March 1, 1985, on the results of the study proposed to be required by subsection (a) of this section of the Committee bill. The report would be required to include (1) a description of the study results, (2) information regarding the VA's ability to provide treatment to the number of veterans identified in the study as suffering from post-traumatic stress disorder and related readjustment problems, (3) a description of VA policy and procedures for providing disability compensation for these veterans, (4) a description of VA activities to coordinate VA health-care and compensation programs with respect to post-traumatic stress disorder, and (5) recommendations for legislative or administrative action or both as the Administrator considers appropriate in light of the study results.

*Subsection (c) of section 103* would provide that, for the purposes of this section of the Committee bill, the terms "veteran", "service-connected", "active duty", and "Vietnam era" shall have the meaning provided in section 101(2), (16), (21), and (29), respectively, of title 38, United States Code.

*Section 103—Costs:* Enactment of the provisions of section 103 is estimated to entail costs of \$0.5 million in fiscal year 1984.

#### *Section 104*

Would amend chapter 17 of title 38, relating to VA hospitals, nursing home, domiciliary, and medical care, to authorize the provision of preventive health care as part of medical service and to mandate the conduct of a pilot program of preventive health-care services for certain service-connected disabled veterans.

*Subsection (a) of section 104* would amend paragraph (6) of present section 601 of title 38, relating to the definition of the term "medical services", to include, in the cases of persons otherwise receiving care or services under chapter 17, preventive health-care services as defined in section 662 of title 38, and thus authorize the provision of preventive health-care services to those persons.

*Subsection (b) of section 104* would amend present section 661 of title 38, relating to the purpose of the preventive health-care services pilot program authorized under subchapter VII of chapter 38, to make various modifications to the statement of purpose in order to reflect the provisions of subsection (c) of this section of the Committee bill that would make the pilot program mandatory and would limit the services provided under the pilot program to only those veterans who are otherwise being furnished care or services under chapter 17.

*Subsection (c) of section 104* would amend present section 663 of title 38, relating to a pilot program of preventive health-care services, to mandate (instead of authorize, as under existing law) the conduct of a pilot program of preventive health-care services to certain service-connected disabled veterans; to modify the reference to vet-

erans with service-connected disabilities rated 50 percent or more so as to limit eligibility to those with disabilities so rated who are otherwise receiving health-care services from the VA; to modify the period of the pilot program by eliminating the September 30, 1984, expiration date and to specify that the program be implemented during fiscal years 1985 through 1988; and to make the existing \$15 million cap on fiscal year 1984 expenditures under the pilot program applicable also to each of fiscal years 1985 through 1988. In addition to being required to offer at least one preventive health-care service to each 50-percent-or-more-disabled veteran otherwise receiving VA care and each veteran receiving VA care or outpatient services involving a service-connected disability, the Administrator would be authorized, in carrying out the pilot program, to provide preventive services to other veterans whose service-connected disabilities are rated 50 percent or more.

*Subsection (d) of section 104* would amend present section 664 of title 38, relating to the inclusion of information on the pilot program in the annual reports on VA activities that the Administrator is required by present section 214 to submit to the Congress, to specify that the Administrator would be required to include information on the program in the annual report for each of the years—fiscal years 1985 through 1988 (in addition to the existing requirement regarding the fiscal year 1984 report)—for which the pilot program is proposed to be extended.

*Section 104—Costs:* Enactment of the provisions of section 104 is estimated to entail costs of \$4 million in fiscal year 1984. The costs of this provision in fiscal year 1984 would be offset by cost reductions made by provisions in section 109 of the Committee bill.

#### *Section 105*

Would amend chapter 17 of title 38, relating to VA hospital, nursing home, domiciliary, and medical care, to authorize limited reimbursement for chiropractic services to certain eligible veterans prior to October 1, 1987.

*Paragraph (1) of subsection (a) of section 105* would amend present section 601, relating to definitions, to add a new paragraph (9), as follows:

*New paragraph (9):* Would define the term “chiropractic services” as the manual manipulation of the spine to correct a subluxation of the spine, and not to include physical examinations, laboratory tests, radiologic services, or other tests or services determined by the Administrator to be excluded. Also by virtue of this definition, the VA would pay, under new section 630 of title 38, as proposed to be added by paragraph (2) of this subsection of this section of the Committee bill, only for services that are provided by chiropractors who are licensed and meet the minimum national standards for chiropractors promulgated under section 1861(r)(5) of the Social Security Act (42 U.S.C. 139x5(r)(5)).

*Paragraph (2) of subsection (a) of section 105* would add a new section 630, entitled “Chiropractic services”, to subchapter III of chapter 17, as follows:

*Subsection (a) of section 630:* Would provide for the reimbursement of the reasonable charges, not exceeding the applicable charge in the schedule established under subsection (b)(1) of this



section of the Committee bill, for chiropractic treatment not otherwise covered by health insurance or other reimbursement or payment available to a veteran or, direct payment to the chiropractor of the reasonable charges for chiropractic services provided to the veteran if (1) the treatment was for a service-connected neuromusculoskeletal condition of the spine, (2) the veteran had been furnished hospital care by the VA for a neuromusculoskeletal condition of the spine within a 12-month period prior to the provision of chiropractic services, or (3) the veteran has a service-connected disability rated at 50-percent or more and has been furnished hospital care or medical services by the VA for a neuromusculoskeletal condition of the spine.

*Paragraph (1) of subsection (b) of new section 630:* Would require the Administrator, in consultation with appropriate public and nonprofit private organizations and other Federal departments and agencies that provide reimbursement for chiropractic services, to establish a schedule of reasonable charges for such services consistent with the reasonable charges allowed under title XVIII of the Social Security Act (42 U.S.C. ch. 7), and to compute payments for chiropractic services in accordance therewith.

*Paragraph (2) of subsection (b) of new section 630:* Would limit the amount payable by the VA for chiropractic services provided any one veteran to not more than \$400 in any 12-month period.

*Subsection (c) of new section 630:* Would provide that total expenditures for chiropractic services reimbursed under this new section may not exceed \$2 million in any fiscal year and that no reimbursement or payment may be made for chiropractic services furnished after September 30, 1987.

*Paragraph (3) of subsection (a) of section 105* would amend the table of sections at the beginning of chapter 17 to reflect the addition of the new section 630 proposed to be added by the amendment made by subsection (a)(2) of this section of the Committee bill.

*Subsection (b) of section 105* would require the Administrator, not later than December 31, 1984, and not later than December 31 of each of the next 3 years, to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on the use made of the authorities provided for in the amendments made by subsection (a) of this section of the Committee bill. Each such report would be required to specify—

(1) the number of requests by eligible veterans for reimbursement or payment for chiropractic services in the then-most recent fiscal year under new section 630 (as proposed to be added by subsection (a)(2) of this section of the Committee bill) and the number of such veterans who made such requests;

(2) the number of reimbursements or payments made by the Administrator under the new section in that fiscal year and the number of veterans for whom such reimbursements or payments were made; and

(3) the total amount of expenditures by the Administrator for such reimbursements and payments under such new section in that fiscal year.

*Section 105—Costs:* Enactment of the provisions of section 105 is estimated to entail costs of \$1.7 million in fiscal year 1984.

### Section 106

Would expressly provide the VA with and clarify the existing authority to conduct a program of referral for community residential care and thus codify authority for an existing program under which the VA refers veteran-patients to and helps them in obtaining placements in private, VA-approved community residential-care facilities.

*Subsection (a) of section 106* would amend subchapter III of present chapter 17 of title 38, containing miscellaneous provisions relating to hospital and nursing home care and medical treatment, to add a new section 630A as follows:

*New section 630A.—Transfers for community residential care:* Would express the authority for and establish certain terms and conditions for the operation by the VA of a community residential-care program as follows:

*Subsection (a) of new section 630A:* Would authorize the Administrator, subject to the terms and conditions set forth elsewhere in this new section and in regulations prescribed by the Administrator, to assist certain veterans by referring them for, and helping them obtain, placement in community residential-care facilities. Veterans to whom the VA would be authorized to provide such assistance are those who are being furnished hospital, domiciliary, or nursing home care or out-patient treatment by the VA or were furnished such care and services within the previous 12 months. The term "community residential-care facility" is defined in subsection (e) of new section 630A.

*Paragraph (1) of subsection (b) of new section 630A:* Would prohibit the VA from referring a veteran to or helping the veteran obtain placement in a community residential-care facility unless the Administrator has approved the facility in accordance with paragraph (2) of subsection (b) of new section 630A.

*Paragraph (2) of subsection (b) of new section 630A:* Would require that the VA's approval of a community residential-care facility be based upon a VA determination, upon inspection of the facility, that it meets the standards set forth in regulations prescribed by the Administrator. Those standards would be required to include (1) health and safety criteria, including a requirement of compliance with applicable State laws and local ordinances relating to health and safety, (2) a requirement that the charges be reasonable, as determined by the VA, giving consideration to relevant factors, such as the level of care, supervision, and other services to be provided, the cost of goods and service in the geographic area, and comparability with other facilities providing similar services in the same geographic areas, (3) criteria for determining the resources that a community residential-care facility needs in order to provide an appropriate level of services to veterans, and (4) such other criteria as the Administrator considers appropriate to protect the welfare of veterans placed in community residential-care facilities.

*Paragraph (3) of subsection (b) of new section 630A:* Would provide that payment of any of the charges for a veteran's care at a community residential-care facility shall not be the responsibility of either the United States Government or the VA.

*Paragraph (1) of subsection (c) of new section 630A:* Would require the VA to carry out periodic inspections of community residential-care facilities to determine their continued compliance with VA standards. Those VA standards and any reports of VA inspections of the facilities would be required, to the extent possible, to be made available to all Federal, State, and local agencies charged with the responsibility of licensing or otherwise regulating or inspecting such facilities. This requirement for making standards and inspection reports available derives from and parallels the requirements in present section 620(b) relating to VA standards for and inspections of community nursing home facilities.

*Paragraph (2) of subsection (c) of new section 630A:* Would require the VA, when it finds a community residential-care facility to be not in compliance with VA standards, to cease referring veterans to the facility; and, in that situation, would authorize the VA, with the permission of the veteran (or the veteran's guardian or conservator or other person with lawful authority to give permission on behalf of the veteran) to assist in removing the veteran from the facility. Regulations to be prescribed to carry out this paragraph would be required to provide for reasonable notice and, upon the facility's request, a hearing before any above-mentioned actions are taken.

*Subsection (d) of new section 630A:* Would require the Administrator to prescribe regulations to carry out this new section 630A.

*Subsection (e) of new section 630A:* Would define the term "community residential-care facility" as a residential facility that provides, at a minimum, room and board and such limited personal care for and supervision of residents as the VA determines, in accordance with regulations that the Administrator would be required to prescribe, are necessary for the residents' health, safety, and welfare. It is intended that generally these facilities will be located in residential neighborhoods or other community-based settings that provide a normal, safe, and psychologically healthful environment for the residents.

*Subsection (b) of section 106* would amend the table of section at the beginning of chapter 17 of title 38 to reflect the addition of proposed new section 630A.

*Section 106—Costs:* Enactment of the provisions of section 106 is estimated to entail no costs in fiscal year 1984.

### *Section 107*

*Subsection (a) of section 107* would amend present section 641(a) of title 38, relating to per diem payments to the States for providing care in State home facilities to veterans who are eligible for care in VA facilities, to increase the rates of per diem payments for domiciliary care from \$6.35 to \$7.30, for nursing home care from \$12.10 to \$13.95, and for hospital care from \$13.25 to \$15.25.

*Paragraph (1) of subsection (b) of section 107* would provide that except as provided in paragraph (2) of this subsection of the Committee bill, the increases in per diem rates proposed to be made by subsection (a) shall take effect on April 1, 1984.

*Paragraph (2) of subsection (b) of section 107* would provide that, for the months prior to September 1984, the increases in per diem rates proposed to be made by subsection (a) shall take effect only if

adequate funds for such increases are specifically provided for such increases are specifically provided for such purpose in an appropriations Act. The effect of this provision is that the increases take effect not later than September 1, 1984.

*Section 107—Costs:* Enactment of the provisions of section 107 is estimated to entail costs of \$3.5 million in fiscal year 1984.

#### *Section 108*

*Subsection (a) of section 108* would amend present section 601(4)(C) of title 38, which defines "Veterans' Administration facilities" as including private facilities in certain circumstances and, by virtue of the use of that term in other, operative provisions of chapter 17, authorizes the furnishing of contract care (so-called "fee" care or "fee basis" care) under those circumstances, so as to extend for one year—from September 30, 1983, until September 30, 1984—the VA's authority to contract for the furnishing in the Commonwealth of Puerto Rico and in the Virgin Islands (and other Territories and possessions of the United States) of hospital care for the care of non-service-connected disabilities and such medical services as will obviate the need for hospital admission for the care of such disabilities.

*Subsection (b) of section 108* would require the Administrator, not later than December 1, 1983, to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing the plans of the Administrator, and the reasons therefor, for meeting the health-care needs of veterans in Puerto Rico and the Virgin Islands who are eligible for VA health care and, most particularly, the health-care needs of the veterans in that population with service-connected disabilities. The report would be required to take into account a report by the VA's Office of Inspector General (Report No. 3R2-A05-043, dated February 22, 1983, entitled "Report of Special Audit, Veterans' Administration Medical and Regional Office Center, San Juan, Puerto Rico") and to include, with respect to any construction recommended in the report as to which a prospectus would be required under section 5004(b) of title 38, a prospectus that meets the requirements of that section.

*Section 108—Costs:* Enactment of the provisions of section 108 is estimated to entail costs of \$14.1 million in fiscal year 1984.

#### *Section 109*

Would realign certain resources within the VA health-care budget by requiring that approximately \$20 million in fiscal year 1984 funds be redirected from VA health-care beneficiary travel-expense reimbursements under present section 111 of title 38, relating to the reimbursement of certain VA beneficiaries for the cost of travel to and from VA facilities, to the provision of community (non-VA) nursing home care and adult day health-care and preventive health-care services to eligible veterans.

*Subsection (a) of section 109* would amend subsection (e) of present section 111 of title 38, relating to the Administrator's authority in certain circumstances to restrict VA beneficiaries' eligibility for reimbursement for the expenses of their travel to and from VA facilities, to add a new paragraph (5), as described below.



However, under the provisions of subsection (e) of this section of the Committee bill, new paragraph (5) would lose effect if the enactment of any law, or any action of the Director of the Office of Management and Budget in connection with that law, precludes shifting \$20 million in fiscal year 1984 from beneficiary travel to community nursing home care, adult day health care, and preventive health care.

*Subparagraph (A) of new paragraph (5):* Would authorize and require the Administrator—for the purposes of achieving compliance with the fiscal year 1984 limit proposed in subsection (b) of this section of the Committee bill to be placed on travel reimbursements for VA health-care beneficiaries—to prescribe regulations restricting, effective October 1, 1983, the making of payments for such reimbursements to the extent necessary to achieve compliance with that limitation. The restrictions imposed by the new regulations would not be permitted to apply to persons receiving title 38 benefits for or in connection with a service-connected disability.

The Administrator would have broad discretion in fashioning the restrictions that would result in limiting, to the extent specified, fiscal year 1984 obligations. However, the Committee notes its intention that the Administrator take into account the special circumstances of veterans in Alaska and Hawaii, States in which there are no VA hospitals and the geography of which poses particular travel problems for many veterans.

*Subparagraph (B) of new paragraph (5):* Would authorize the Administrator to keep in effect after fiscal year 1984 the substantive regulatory provisions, prescribed under subparagraph (A) of this new paragraph, so restricting travel-reimbursement payments. However, in addition to being subject to the provisions subsection (e) of this section of the Committee bill, the authority under this subparagraph to maintain those regulatory provisions after fiscal year 1984 would also lose effect, under subsection (d) of this section of the Committee bill, if the Comptroller General determines that the Administrator has not added a total of at least \$20 million in obligations for community nursing home care, adult day health care, and preventive health-care services to the amounts included in the fiscal year 1984 budget for those items.

*Subsection (b) of section 109* would limit to \$71,209,000 the amount of VA medical care account funds that may be obligated in fiscal year 1984 for beneficiary travel reimbursements under section 111 of title 38. This amount is \$20 million less than the amount included in the President's fiscal year 1984 budget for the VA's medical care account for this purpose.

However, under the provisions of subsection (3) of this section of the Committee bill, this subsection imposing the cap would become ineffective if a fiscal year 1984 appropriations measure, or action of the Director of OMB, makes it impossible for the \$20 million that the cap would save in beneficiary travel reimbursements to be redirected to the provision of community nursing home care, adult day health care, and preventive health-care service as specified in subsection (c)(1) of this section of the Committee bill.

*Paragraph (1) of subsection (c) of section 109* would require the Administrator to direct that, of the funds appropriated to the VA's medical care account for fiscal year 1984, a total of not less than

\$20 million be made available for obligation in that year—over and above the amount that was requested in the President's budget—for the provision to veterans of care in community nursing homes, adult day health care (under the pilot program to be established by the amendments made by section 101 of the Committee bill), and preventive health-care services. The preventive health-care services to which additional funding would be directed would include preventive care provided as part of VA hospital and nursing home care and outpatient treatment to eligible veterans (as would be authorized by the amendment proposed to be made by section 104(a) of the Committee bill) and under the preventive health-care services pilot program for certain service-connected disabled veterans (as it would be revised and made mandatory by amendments proposed to be made by section 104(c) of the Committee bill). The Administrator would have the discretion to determine how to allocate the \$20 million amount among these programs as long as a significant amount were made available for care or services in each of the following four categories: (1) community nursing home care and adult day health care under section 620 of title 38, (2) preventive services under section 610 of title 38 (as part of VA hospital and nursing home care), (3) preventive services under section 612 of title 38 (as part of VA outpatient treatment), and (4) preventive services under subchapter VII of chapter 17 of title 38 (pilot program).

*Paragraph (2) of subsection (c) of section 109* would require that, if at any time during fiscal year 1984 the Administrator estimates that beneficiary travel reimbursements from the VA's medical care account will be less than \$71,209,000 (the cap amount), the Administrator direct the difference to be obligated for the categories of care and services described in paragraph (1) of subsection (c) of this section of the Committee bill (discussed above) or for VA health-care activities (otherwise authorized) designed to avoid the need for, or to shorten periods of institutionalization—such as the VA's hospital-based home care program. Although the Administrator would be required to direct that the entire amount by which beneficiary travel obligations are expected to be less than \$71,209,000 be obligated, the Administrator would have complete discretion as to how any such amount would be allocated. Thus, the Administrator would have the latitude to direct all, part, or none of that amount to any particular category of care, services, or activities.

*Paragraph (3) of subsection (c) of section 109* would require the Administrator, not later than September 15, 1983—16 days before the start of fiscal year 1984—to submit to the House and Senate Veterans' Affairs Committees a report containing the following information: (1) the total amount the Administrator estimates—taking into account the regulations restricting beneficiary travel reimbursement payments that the Administrator would be authorized and required to prescribe under proposed new paragraph (5) of subsection (e) of section 111 of title 38 (as proposed to be added by subsection (a) of this section of the Committee bill)—will be obligated in fiscal year 1984 medical care account funds for beneficiary travel reimbursements; (2) the amounts requested in the President's fiscal year 1984 budget for the care and services specified in paragraph (1) of subsection (c) of this section of the Committee bill

under each section and the subchapter specified in that paragraph; (3) the amounts over and above the President's fiscal year 1984 appropriation request that the Administrator has directed be made available for obligation for the specified care and services under each such section and that subchapter; and (4) the justification for the amounts allocated to each category. The Committee notes that this report both would provide the Veterans' Affairs Committees with more detailed information than is available in the President's and the Veterans' Administration's budget documents with respect to the amount included in the President's fiscal year 1984 budget for the VA's medical care account for preventive health care and would provide a check on how the Administrator has interpreted, and intends to comply with, the substantive provisions of this section of the Committee bill shortly before the fiscal year involved begins.

*Paragraph (4) of subsection (c) of section 109* would require the Administrator, at the time that the President's fiscal year 1985 budget is transmitted, to submit to the Veterans' Affairs Committees a report giving a monthly breakdown as to how the redirected funds are being used and specifying any revisions made in the allocation of those funds (and the justification for any such revisions) since the September 15, 1983, report was submitted.

*Paragraph (1) of subsection (d) of section 109* would require the Administrator, not later than August 1, 1984, to submit to the Veterans' Affairs Committees and the Comptroller General a report containing—with respect to each category of care and services described in subsection (c)(1) of this section of the Committee bill (community nursing home care, adult day health care, and preventive health-care services as part of VA inpatient and outpatient care generally and for certain service-connected disabled veterans under the pilot program)—information, for each month of fiscal year 1984 for which it is then available, as to the amounts obligated and the amounts by which the obligations have exceeded one-twelfth of the amounts requested in the President's fiscal year 1984 budget, and, taking into account that month-by-month breakdown of actual obligations for each category of care and services, as to the amounts that the Administrator estimates (together with the Administrator's justification for the estimates) have been or will be obligated in each remaining month of fiscal year 1984. This information, subject to confirmation or revision by the Comptroller General under paragraph (2) of subsection (d) of this section of the Committee bill, would be used to determine whether the full \$20 million can reasonably be expected to be added to the budgeted amounts for those categories of care and services and obligated for them during fiscal year 1984.

*Paragraph (2) of subsection (d) of section 109* would require the Comptroller General, not later than September 1, 1984 (one month after the due date of the Administrator's report under paragraph (1) of subsection (d) of this section of the Committee bill, to submit to the Veterans' Affairs Committees a report containing (1) the results of an analysis by the Comptroller General, conducted in consultation with the Director of the Congressional Budget Office, of the report required by paragraph (1) of subsection (d) of this section of the Committee bill, to be submitted by the Administrator and (2)



the Comptroller General's determination whether the total obligations for the categories of care and services described in subsection (c)(1) of this section of the Committee bill can reasonably be expected to exceed by at least \$20 million the amounts requested therefor in the President's fiscal year 1984 budget.

*Paragraph (3) of subsection (d) of section 109* would provide that, if the Comptroller General's determination under paragraph (2) of subsection (d) of this section of the Committee bill is that the amount by which the total fiscal year 1984 obligations for those categories of care and services will exceed the total amount that the President requested for them cannot reasonably be expected to be \$20 million or more, subparagraph (B) of new paragraph (5) (as proposed to be added by subsection (a) of this section of the Committee bill) of present section 111(e) of title 38, which would authorize the Administrator to keep in effect after fiscal year 1984 regulations imposing certain restrictions on beneficiary travel reimbursement, would lose effect on September 30, 1984, as if repealed.

*Subsection (e) of section 109* would require the Comptroller General, after consulting with the Administrator and not later than 45 days after the enactment of each law making appropriations to the VA's medical care account or in any way restricting the obligation or expenditure of any funds appropriated to it for fiscal year 1984, to submit to the Veterans' Affairs Committees a report containing the Comptroller General's determination whether that law, or any action of the Director of OMB in connection with that law, makes it impossible for the Administrator to comply with the requirement in subsection (c)(1) of this section of the Committee bill to add \$20 million to the total account included in the President's budget for community nursing home care, adult day health care, and preventive health-care services without using medical care account funds intended by the Congress to be used for a purpose other than beneficiary travel reimbursements. If the Comptroller General determines that the law in question or action by the Director of OMB, such as an OMB-directed reprogramming or Executive-branch deferral or rescission proposal, does make it impossible for the Administrator to comply with that requirement without diverting non-travel-reimbursement funds, the amendment made by subsection (a) of this section of the Committee bill, which authorizes and requires regulations restricting beneficiary travel payments to a certain extent, and provisions of subsection (b) of this section of the Committee bill, which place a \$71,209,000 cap on fiscal year 1984 obligations for beneficiary travel reimbursements, would lose effect as if repealed. The date on which that amendment and those provisions would lose effect would be the forty-sixth day after the enactment of such a law.

For example, if the regular fiscal year 1984 appropriations law (or the Director of OMB in apportioning the funds to the VA) were to provide less than \$91,209,000 (the amount in the President's budget) for beneficiary travel reimbursements in the VA's medical care account and provide no increase over the President's budget for community nursing home care, adult day health care, and preventive health-care services, the Committee intends that the determination be that the law (or the Director) made the Administrator's compliance impossible. Any other situation in which the total



of the appropriation amounts made available to the VA for those categories of care and services and for beneficiary travel would not be at least as much as the total of the amounts that the President had requested for those items in the VA's medical care account would produce the same result.

In contrast, if the total amounts of the appropriations available to the VA for those categories and for beneficiary travel equalled or exceeded the total of the amount of the President's request for them and if the Administrator was not precluded from achieving any necessary shifting of the funds, compliance would be considered possible. Likewise, if an appropriation measure were to make the shift directly—by reducing the President's request for beneficiary travel to \$71,209,000 and providing increases totalling \$20 million for community nursing home, adult day care, and preventive health-care services compliance would obviously be considered possible.

The Committees note that ascertaining Congressional intent regarding the purpose for which the medical care account funds are appropriated requires an examination of the legislative history of the appropriations measure in question, including the President's budget documents and the documents submitted by the VA in justification of the budget for the agency.

*Subsection (f) of section 109* would require the Administrator, not later than the date on which the President's budget for fiscal year 1986 is transmitted (approximately four months after the end of fiscal year 1984), to submit to the Veterans' Affairs Committees a report containing (1) information as to the amounts of VA medical care account funds actually obligated in fiscal year 1984 for beneficiary travel reimbursements and for each category of care and services described in subsection (c)(1) of this section of the Committee bill, and any amounts obligated pursuant to subsection (c)(2) and the purposes for which they were spent; and (2) explanations for any significant differences between actual obligations and the amounts of the obligations that the Administrator, in the Administrator's August 1, 1984, report pursuant to subsection (d)(1) of this section of the Committee bill, had estimated would be made.

*Section 109—Costs:* Enactment of the provisions of section 109 is estimated to entail cost savings of \$18 million in fiscal year 1984. When considered in conjunction with the provisions of sections 101 and 104 of the Committee bill, this section is estimated to entail net costs savings of \$1 million in fiscal year 1984.

## TITLE II—PROVISIONS TO IMPROVE THE RECRUITMENT AND RETENTION OF CERTAIN PERSONNEL

### *Section 201*

Would amend present section 4104 of title 38, relating to the Administrator's appointment of individuals in the VA's Department of Medicine and Surgery (DM&S) as follows:

*Clause (1) of section 201* would amend present paragraph (2) to delete "physical therapists" as that occupation is proposed to be included—with the term modified to specify "licensed physical therapists"—in new paragraph (3) of such section 4104 (as proposed to be added by clause (4) of this section of the Committee bill).

*Clause (2) of section 201* would update the terminology in present paragraph (2) by substituting "microbiologist" for "bacteriologist".

*Clause (3) of section 201* would strike out the period at the end of present paragraph (2) of such section and insert instead a semicolon.

*Clause (4) of section 201* would add a new paragraph (3) to add certified or registered respiratory therapists, licensed physical therapists, and licensed practical or vocational nurses to the listing of occupations in DM&S in which the Administrator may make appointments. By virtue of this amendment and other amendments proposed by other sections in this title of the Committee bill, the Administrator would be given new authorities with reference to hiring, promoting, and setting rates of pay for personnel in these three occupations in DM&S.

### *Section 202*

Would amend present section 4105 of title 38, relating to qualifications of appointees in DM&S, to make a number of technical and conforming changes as follows:

*Clause (1) of subsection (a) of section 202* would amend clause (1) of present section 4105(a) to change to "physician" the reference to "physicians", thereby conforming the occupational reference in that clause to the others in that subsection, which are in the singular.

*Clause (2) of subsection (a) of section 202* would delete clauses (8) and (9) of present section 4105(a). The substance of these two clauses is proposed to be combined and included in revised clause (9) (as proposed to be added by clause (4) of this subsection of the Committee bill as described below).

*Clause (3) of subsection (a) of section 202* would redesignate present clause (10) of section 4105(a) as clause (8).

*Clause (4) of subsection (a) of section 202* would add to present section 4105(a) revised clause (9) setting forth the qualifications—"such medical, dental, scientific, or technical qualifications as the Administrator shall prescribe"—for the occupations listed in present clauses (8) and (9) (as proposed to be deleted by clause (2) of this subsection of the Committee bill) as well as the occupations listed in paragraphs (2) and (3) of section 4104 of title 38 (as proposed to be amended by section 201 of the Committee bill).

*Subsection (b) of section 202* would amend present section 4105(b) of title 38, relating to the requirement of United States citizenship for appointment as a DM&S employee in an occupation listed in paragraph (1) of section 4104, to delete the repetition of the list in section 4105(b) and insert instead a cross-reference to that paragraph.

### *Section 203*

Would amend present section 4106 of title 38, relating to the appointment and promotion of certain employees in DM&S, to grant the Administrator new authorities with respect to the appointment in DM&S of personnel in the occupations listed in new paragraph (3) of section 4104 of title 38 (as proposed to be added by section 201 of the Committee bill).

*Subsection (a) of section 203* would amend present section 4106 to add a new subsection (g) as follows:

*Paragraph (1) of new subsection (g).* Would authorize the Administrator, upon the recommendation of the Chief Medical Director, to use the authority in subsection (a) of present section 4106, under which the Administrator may establish the qualifications of certain categories of DM&S personnel without regard to civil-service requirements, to establish the qualifications for and to appoint individuals to positions in occupations listed in new paragraph (3) of section 4104 (as proposed to be added by clause (4) of section 201 of the Committee bill) and to use the authority in subsection (c) of present section 4106, under which the Administrator prescribes regulations for promotion examinations for certain categories of DM&S personnel and for advancements within grade in increments of the minimum rate of basic pay of the grade concerned, for the promotion of VA employees serving in the occupations listed in that new paragraph.

*Paragraph (2) of new subsection (g):* Would require the Administrator, in using the authority in subsection (a) to appoint individuals in the DM&S occupations listed in proposed new paragraph (3) of section 4104, to apply the principles of veterans' preference set forth in subchapter I of chapter 33 of title 5, United States Code.

*Subsection (b) of section 203* would require the administrator, not later than 90 days after the date of enactment of the Committee bill, to publish in the Federal Register for public review and comment, proposed regulations for the continued implementation of paragraph (2) of new subsection (g) of present section 4106 of title 38 (as proposed to be added by subsection (a) of this section of the Committee bill), and not later than 180 days after the date of the enactment, to publish in the Federal Register final regulations for such continued implementation.

#### *Section 204*

Would amend present section 4107, relating to the pay of various categories of DM&S personnel, to provide the Administrator with new authorities that the Administrator may use as the Administrator determines necessary to recruit and retain certified or registered therapists, licensed physical therapists, and licensed practical or vocational nurses.

*Clause (1) of section 204* would amend subsection (f) of present section 4107, relating to the Administrator's authority to compensate DM&S employees in certain occupations by use of the nurse pay authorities in present section 4107(b)(1) and (e), to authorize the Administrator, when the Administrator determines it to be necessary in order to obtain or retain the services of certified or registered respiratory therapists, licensed physical therapists, or licensed practical or vocational nurses, to pay persons employed in such occupations additional pay on the same basis as such pay is paid to nurses under present section 4107(e). The Administrator's authority under this amendment to pay such persons on that basis would be exercisable on whatever geographic basis the Administrator determines necessary for recruitment and retention purposes.

*Clause (2) of section 204* would amend subsection (g) of present section 4107, relating to basic pay for DM&S employees in certain

occupations, to provide the Administrator with authority, under certain circumstances, to modify rates of basic pay for individuals serving as certified or registered respiratory therapists, licensed physical therapists, and licensed practical or vocational nurses, as follows:

*Subclause (A) of clause (2) of section 204* would amend clause (A) of paragraph (1) of present section 4107(g), relating to the Administrator's authority to increase, for recruitment and retention purposes and on any geographic basis selected by the Administrator, the minimum, intermediate, or maximum rates of pay of DM&S personnel in certain occupations, to add certified or registered respiratory therapists, licensed physical therapists, and licensed practical or vocational nurses to the occupations with respect to which that authority may be exercised.

*Subclause (B) of Clause (2) of section 204* would amend paragraph (3) of present section 4107(g), relating to a limitation on the amount by which the Administrator may raise rates of basic pay under paragraph (1) of such section (as proposed to be amended by subclause (A) of clause (2) of this section of the Committee bill)—which limits the amount of any increase in the maximum rate for any grade to the amount by which the maximum for such grade exceeds the minimum for such grade—to add licensed physical therapists to nurse anesthetists as an occupation to which that limitation does not apply.

*Subclause (C) of Clause (2) of section 204* would amend paragraph (4) of present section 4107(g), relating to the Administrator's exercise of the authority under paragraph (1) of present section 4107(g) (as proposed to be amended by subclause (A) of clause (2) of this section to the Committee bill) to increase, for recruitment and retention purposes, rates of basic pay for certain occupations in DM&S not included in the separate title 38 system, to exclude from the provision subjecting the Administrator's exercise of that authority to Presidential review decisions by the Administrator to raise the rates of pay for persons employed in occupations listed in new paragraph (3) of section 4104 (as proposed to be added by clause (4) of section 201 of the Committee bill).

#### *Section 205*

Would amend present section 4410(a) of title 38, relating to the appointment of disciplinary boards within DM&S to determine charges of inaptitude, inefficiency, or misconduct of certain DM&S employees, to require that the majority of employees on such a board be employed in the same occupation as the employee who is the subject of the charges. Under current law, that requirement exists only with respect to dentists.

#### *Section 206*

*Cause (1) of section 206* would amend present section 4111 of title 38, relating to the Administrator's authority to appoint to DM&S under civil-service laws, rules, and regulations personnel to certain occupations, to redesignate the existing provision as subsection (a).

*Clause (2) of section 206* would amend subsection (a) (as proposed to be redesignated by clause (1) of this section of the Committee bill) to specify that personnel appointed to DM&S positions in the



occupations listed in new paragraph (3) of section 4104 (as proposed to be added by clause (4) of section 201 of the Committee bill) are not among the personnel that must be appointed under civil-service laws, rules, and regulations.

*Clause (3) of section 206* would further present section 4111 to add a new subsection (b) as follows:

*New subsection (b):* Would authorize the Administrator, after considering an individual's existing pay or higher or unique qualifications or the special needs of the VA, to appoint an individual to a position in DM&S providing direct patient-care services or services incident to direct patient services at a salary rate above the minimum rate of the appropriate grade for the position.

#### *Section 207*

Would require the Administrator and the Director of the Office of Personnel Management to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on certain activities relating to DM&S personnel.

*Paragraph (1) of subsection (a) of section 207* would require the Administrator and the Director of the Office of Personnel Management, not later than January 1, 1984, to submit to the Committees a joint report on the status of efforts to carry out the recommendations made in the report prepared by the VA pursuant to section 117 of Public Law 96-330. The report is entitled "Study of the Feasibility and Desirability of Converting Selected Health Care Occupations of Title 38, United States Code" and was transmitted to the Committees on September 1, 1982.

*Paragraph (2) of subsection (a) of section 207* would specify that the report required by paragraph (1) of subsection (a) of this section of the Committee bill must contain the following:

(1) With respect to each recommendation other than the conversion recommendation made in the report cited in the above analysis of paragraph (1) of subsection (a) of this section of the Committee bill, information on the decision that has been made as to whether the recommendation is being implemented in the manner described in the report and, if not, as to whether it is to be implemented in a modified form or not implemented and a statement of the reasons for the decision and of the position of each agency with respect to each recommendation and decision.

(2) The timetable for the actions planned for the implementation of each recommendation that is being implemented either in its original form or as modified.

(3) Any further recommendation of the Administrator or Director or both for legislative or administrative action or both relating to the subject matter of the report.

(4) Such other information relating to the subject matter of the report as the Administrator or the Director or both considers appropriate.

*Paragraph (1) of subsection (b) of section 207* would require the Administrator, not later than 90 days after the date of the enactment of the Committee bill, to submit to the Committees a report on the implementation of the amendments made by sections 201 through 206 of the Committee bill. Such implementation report

would be required to contain a description of the steps taken and planned to be taken., and reasons therefor, to exercise the authorities provided by such amendments and an explanation of the extent to which such authorities have not been or are not planned to be exercised.

*Paragraph (2) of subsection (b) of section 207* would require the Administrator, not later than September 30, 1985, to submit to the Committees a report describing the results of the exercise of the authorities provided in the amendments made by sections 201 through 206 of the Committee bill and the efforts under present section 410i(b) of title 38, relating to the Administrator's responsibility for a program of education and training of health personnel, to develop and carry out programs of education and training for career advancement for nursing assistants, noncertified, nonregistered inhalation therapists, and other para-professionals employed in DM&S who provide either direct patient-care services or services incident to direct patient-care services. The report would also be required to contain an evaluation of the effects of those amendments and programs on the recruitment and retention of VA employees and on VA employee's productivity and morale and effectiveness in carrying out the missions of the VA, and such recommendations for administrative or legislative action, or both, as the Administrator considers appropriate in light of that evaluation.

*Title II—Costs:* Enactment of the provision of title II is estimated to entail costs of \$2.3 million in fiscal year 1984.

### TITLE III.—WOMEN VETERANS

#### *Section 301*

Would amend present chapter 3 of title 38, relating to various administrative aspects of Veterans' Administration operations, to establish an Advisory Committee on Women Veterans.

*Subsection (a) of section 301* would add a new section 222, entitled "Advisory Committee on Women Veterans". This new section would consist of three subsections as follows:

*Subsection (a) of new section 222:* Would require the Administrator to establish an advisory committee to be known as the "Advisory Committee on Women Veterans" and to appoint its members from the general public; would require that the membership of the Committee include appropriate representatives of women veterans, individuals who are recognized authorities in fields pertinent to the needs of women veterans (including the gender-specific health-care needs of women), and appropriate representatives of both female and male service-connected-disabled veterans, including at least one of each, and, as ex officio members, the VA's Chief Medical Director and Chief Benefits Director, or their designees, and one public member and one military member of the Department of Defense Advisory Committee on Women in the Services selected by the Administrator after consultation with the Secretary of Defense; would authorize the Administrator to invite representatives of other departments and agencies of the United States to participate in the meetings and other activities of the Committee; would authorize the Administrator to determine the number, terms of service, and pay and allowances of members (except that a term of

service of any member could not exceed three years) and to reappoint any member for additional terms of service; and would require the Committee to meet not less than three times in fiscal year 1984 and thereafter as determined by the Committee but not less than two times each fiscal year.

*Subsection (b) of new section 222:* Would require the Administrator, on a regular basis, to consult with and seek the advice of the Committee with respect to the administration of benefits under title 38 to women veterans, reports and studies pertaining to such veterans, and the needs of such veterans with respect to compensation, health care, rehabilitation, outreach, and other benefits and programs administered by the VA.

*Subsection (c) of new section 222:* Would require the Committee to submit to the Administrator by July 1 of each year, beginning in 1984, an annual report on the programs and activities of the VA that pertain to women veterans. Within 30 days after receiving each report, the Administrator would be required to submit the report, along with any comments the Administrator considers appropriate, to the Congress. The reports would be required to contain an assessment of the needs of women veterans with respect to compensation, health care, rehabilitation, outreach, and other benefits and programs administered by the VA, a review of VA programs and activities designed to meet those needs, and such recommendations, including recommendations for administrative or legislative action, as the Committee considers appropriate. In addition, the Committee would be authorized to submit to the Administrator such additional reports and recommendations as the Committee considers appropriate. The Administrator would be required to include a summary of all such additional recommendations and reports in the next annual report submitted to Congress pursuant to present section 214 of title 38.

*Subsection (b) of section 301* would amend the table of sections at the beginning of chapter 3 to reflect the changes proposed by this section of the Committee bill.

*Section 301—Costs:* Enactment of the provisions of section 301 is estimated to entail no significant costs.

### *Section 302*

Would amend present section 601(4)(C) of title 38—which defines “Veterans’ Administration facilities” as including private facilities in certain circumstances, and, thus, by virtue of the use of that term in certain other operative provisions of chapter 17 of title 38, provides authority for the furnishing of contract hospital care or medical services (so called “fee” care or “fee basis” care) under those circumstances—so as to expand that authority for a time-limited period to authorize the Administrator to provide certain outpatient medical services to women veterans on a fee basis.

*Subsection (a) of section 302* would amend present section 601(4)(C)(iv) in order to provide authorization, until September 30, 1989, for the Administrator to furnish, on a fee basis, such outpatient medical services as (by virtue of the reference to “Veterans’ Administration facilities” in section 612(f)(1)) are reasonably necessary to obviate the need for hospital admission for care for the non-

service-connected, gender-related disabilities of women veterans which the VA itself is not able to treat.

*Paragraph (1) of subsection (b) of section 302* would require the Administrator, at the time the President's budget is submitted for each of fiscal years 1985 through 1989 and as part of the VA's budget documents, to report to the appropriate Committees of the Congress on the Administrator's plans for and estimated utilization of the authority provided in subsection (a) of this section of the Committee bill in the fiscal year for which the budget is submitted and the activities undertaken and planned with respect to such authority in the then-current fiscal year. Also, in the reports submitted in fiscal years 1986 through 1989, the Administrator would be required to provide information on the use of that authority in the prior fiscal year.

*Paragraph (2) of subsection (b) of section 302* would require the Administrator, not later than September 30, 1988, to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate setting forth the Administrator's recommendations, and reasons therefore, as to whether the September 30, 1989, expiration date for the authority provided in subsection (a) of this section of the Committee bill should be extended or the authority should be made permanent, together with any other recommendations for legislative or administrative actions the Administrator considers appropriate with respect to the VA's meeting the gender-related health care needs of women veterans. Before submitting this report, the Administrator would be required to consult with the Advisory Committee on Women Veterans proposed to be established pursuant to section 301 of the Committee bill. The Advisory Committee would be required to report to the Administrator its views on the Administrator's proposed report, and the Administrator, to include such views in the report to the Congress.

*Section 302—Costs.* Enactment of the provisions of section 302 is estimated to entail no significant costs.

#### TITLE IV—PRESUMPTION CONCERNING DYSTHYMIC DISORDER

##### *Section 401*

Would amend present section 312(b) of title 38, which provides that the diseases listed therein are, in the case of former prisoners of war who were interned for not less than 30 days, presumed to have been incurred or aggravated by active-duty service, to add dysthymic disorder (or depressive neurosis) to the list of those diseases.

*Clause (1) of section 401* would strike out the "or" at the end of clause (8) of present section 312(b).

*Clause (2) of section 401* would add "or" at the end of clause (9) of present section 312(b).

*Clause (3) of section 401* would add, in a new clause (10), dysthymic disorder (or depressive neurosis) to the list of diseases in present section 312(b) as to which a presumption would apply in the case of former prisoners of war who were interned for not less than 30 days.

*Section 401—Costs.* Enactment of the provisions of section 401 is estimated to entail no significant costs.



## TITLE V—STATUS AND ROLE OF ADMINISTRATOR OF VETERANS' AFFAIRS

*Section 501*

Would state Congressional findings with respect to the status and role of the Administrator of Veterans' Affairs and, in light of such findings, express the sense of Congress that the Administrator should be designated by the President as a member of the Cabinet and the President's principal adviser on all veterans matters.

*Subsection (a) of section 501* would state Congressional findings with respect to the status and role of the Administrator of Veterans' Affairs as follows:

(1) That the Nation has an historic and deeply-rooted commitment to providing benefits and services to those who served in the Armed Forces;

(2) That this commitment must be continued and maintained, both to fulfill moral obligations to those who served in the past and to assure those now in the Armed Forces and potential service men and women that the Nation's obligations to those who serve will always be honored;

(3) That the VA is the principal Federal entity responsible for veterans' benefits and programs;

(4) That the VA has a potential population of beneficiaries totaling nearly thirty million veterans and over sixty-million survivors and dependents;

(5) That the VA will distribute over \$13 billion in income maintenance payments and approximately \$1.7 billion in education, training, and rehabilitation assistance payments in fiscal year 1983; operates one of the Federal Government's two major home loan guaranty programs, with over 4 million loans currently guaranteed; administers the largest direct insurance program in the Nation; operates 108 national cemeteries and provides burial assistance for nearly 350,000 deceased veterans annually;

(6) That the VA operates the largest centrally administered-care system—consisting of, among other facilities, 172 hospitals, 226 outpatient clinics, and 97 nursing home care units—in the United States;

(7) That the VA health-care system serves as the primary backup to the medical resources of the Department of Defense in time of war or national emergency involving the use of the Armed Forces in armed conflict;

(8) That, in terms of share of the annual Federal budget, the VA ranks sixth among Federal departments and agencies and that among Federal departments and agencies only the Department of Defense employs more personnel;

(9) That the Administrator of Veterans' Affairs is the principal executive branch official responsible for the administration of veterans' benefits, services, and programs of the VA and for seeking the coordination of veterans' programs administered by other Federal departments and agencies;

(10) That there is a need for greater coordination between the VA, on the one hand, and other Federal entities that either administer veterans programs or provide similar bene-

fits to individuals on a basis other than their status as veterans, on the other hand;

(11) That, by virtue of the Administrator of Veterans' Affairs not being included in the President's Cabinet, the Administrator generally is not included in Cabinet meetings and deliberations and generally does not have the ready access to the President and senior advisers on the President's staff that Cabinet members have; and

(12) That, as a consequence, Presidential decisions affecting veterans and the VA are made from time to time without an understanding of their full impact on veterans and on the VA's performance of its statutory missions.

*Subsection (b) of section 501* would express the sense of the Congress that, in view of the findings in subsection (a) of this section of the Committee bill, the Administrator should be designated by the President as a member of, and full participant in all activities of, the Cabinet and as the President's principal adviser on all matters relating to veterans and their dependents.

*Section 501—Costs:* Enactment of the provisions of section 501 is estimated to entail no cost.

#### TITLE VI.—RADIATION EXPOSURE STUDY AND GUIDE

##### *Section 601*

Would require the VA, through contracts or agreements, to provide for the conduct of an epidemiological study or studies—unless determined not to be scientifically feasible—of the long-term adverse health effects of exposure to ionizing radiation from certain detonations of nuclear devices and to develop and publish an indexed reference guide, derived from existing research-result compilations, regarding the state of medical and other scientific information on any long-term adverse health effects in humans from exposure to radiation, including nuclear-device, medical, and occupational exposures.

*Subparagraph (A) of paragraph (1) of subsection (a) of section 601* would require the Administrator, through contracts or agreements with private or public agencies or persons (other than the Department of Defense or the Department of Energy) and in consultation with the Director of the Office of Technology Assessment, to provide for the conduct of epidemiological study—which would consist of one or more separate studies—of the long-term adverse health (including psychological) effects of exposure to ionizing radiation either from a test detonation of a nuclear device or from service in Hiroshima or Nagasaki, Japan, during the period from September 11, 1945, to July 1, 1946. The study (or studies) would be required to include—to the extent not determined to be scientifically infeasible pursuant to subsection (a)(2)(B) of this section of the Committee bill—but not necessarily be limited to, the study of identifiable prevalent illness, including malignancies, of persons potentially exposed and, as part of the same study or separately, the study of genetic and congenital problems suffered by the natural children of such persons.

*Subparagraph (B) of paragraph (1) of Subsection (a) of section 601* would require the Administrator, in the event the Administrator

determines that it is not feasible to conduct scientifically valid study of some or all of the matters specified in paragraph (1)(A) of this subsection of this section of the Committee bill, to notify promptly the appropriate committees of the Congress of this determination and the reasons therefor.

*Subparagraph (A) of paragraph (2) of subsection (a) of section 601* would require the Director of the Office of Technology Assessment to monitor the development of the protocol or protocols for and the conduct of study under subsection (a)(1)(A) of this section of the Committee bill and to report to the appropriate committees of the Congress at specified times on such monitoring. The monitoring reports would be required to be submitted within 6 months after the date of the enactment of the Committee bill, within 12 months after that date, within 25 months after that date, and annually thereafter until the study is completed. Beginning with the report due to be submitted 25 months after the date of enactment and each subsequent report, the Director's report would be required to contain the Director's review of any comments on the most recent report on the study submitted by the Administrator pursuant to paragraph (5) of subsection (a) of this section of the Committee bill (discussed below). In the event that any protocol for study to be undertaken is not completed by the end of the 12-month period beginning on the date of enactment of the Committee bill, the Director would be required to submit to the appropriate committees of the Congress a report on the status of the protocol at the end of the 60-day period that begins at the end of that 12-month period and thereafter at the end of each succeeding 60-day period until the protocol is completed.

*Subparagraph (B) of paragraph (2) of subsection (a) of section 601* would require the Director, in the event the Administrator notifies the Congress (pursuant to subsection (a)(1)(B) of this section of the Committee bill) of a determination or determinations that scientifically valid study cannot be conducted of some or all matters required by subsection (a)(1)(A) to be studied, to submit to the appropriate committees of the Congress, not later than 60 days after the Administrator's notification, a report evaluating the Administrator's determination and reasons therefor. If the Director concurs with any determination by the Administrator that scientifically valid study of any matter is not feasible, the Committee bill would not require study of that matter is not feasible, the Committee bill would not require study of that matter to be conducted. If the Administrator has determined that taken as a whole study under subsection (a)(1)(A) of this section of the Committee bill is scientifically infeasible and the Director concurs, the requirement for the conduct of epidemiological study would lose effect as if repealed.

*Paragraph (3) of Subsection (a) of section 601* would require the Administrator, not later than 12 months after the date of the enactment of the Committee bill, to submit a report to the appropriate committees of the Congress on the development of a protocol or protocols for the study or studies and, in the event that any protocol for study to be undertaken has not been developed, an estimate of the completion date therefor, together with an estimate of the costs to be incurred in developing the protocol.



*Paragraph (4) of subsection (a) of section 601* would require, when the Administrator has entered into a contract for the conduct of a study under subsection (a)(1)(A) of this section of the Committee bill, that the Administrator and the contractor submit to the appropriate committees of the Congress a joint report containing detailed information on the proposed study, including estimates of the number of individuals to be studied, the length of the study (specifying significant milestones prior to its completion), and the total cost of the study.

*Paragraph (5) of subsection (a) of section 601* would require the Administrator, not later than 24 months after the date of the enactment of the Committee bill and annually thereafter, to submit to the appropriate committees of the Congress a report on the progress of and any results obtained under the study or studies. The Administrator would also be required to include in these reports such comments and recommendations for administrative or legislative action, or both, as the Administrator considers appropriate in light of the progress and results of the study or studies.

*Paragraph (6) of subsection (a) of section 601* would require the Administrator, not later than 90 days after the submission of each annual report required by subsection (a)(5) of this section of the Committee bill and based on the progress and results described in each report, the comments and recommendations thereon, and any other available pertinent information, to publish in the FEDERAL REGISTER, for public review and comment, a description of actions, if any, that the Administrator proposes to take with respect to VA programs. Each such description would be required to include a justification for any such action the Administrator proposes to take.

*Paragraph (7) of subsection (a) of section 601* would specify that the requirement in subsection (a)(5) of this section of the Committee bill that the Administrator submit annual reports on the subsection (a)(1)(A) study or studies shall expire upon the submission of a report after the completion of all study under subsection (a)(1)(A) of this section of the Committee bill.

*Paragraph (1) of subsection (b) of section 601* would require the Administrator, not later than one year after the date of the enactment of the Committee bill, to develop and publish an indexed reference guide on the state of medical and other scientific information on any long-term adverse health (including genetic and psychological) effects in humans from exposure to radiation, including nuclear device, medical, and occupational exposures. This indexed reference guide, which would be required to be designed to provide VA personnel who either furnish health care or adjudicate claims for benefits under title 38 with readily usable information on this issue, would be derived from existing pertinent research-result compilations.

*Paragraph (2) of subsection (b) of section 601* would require the Administrator, not later than 13 months after the date of the enactment of the Committee bill, to submit to the appropriate committees of the Congress a report on the indexed reference guide, together with such comments and recommendations for administrative or legislative action, or both, as the Administrator considers appropriate, including recommendations regarding the need for



any additional research necessary for the resolution of questions as to whether certain adverse long-term health effects result from exposure to radiation and, if it is recommended that additional research is needed, recommendations regarding the departments, agencies, or instrumentalities that should carry it out.

*Paragraph (3) of subsection (b) of section 601* would require the Administrator (1) to distribute the indexed reference guide to VA personnel providing health care or adjudicating claims for benefits and to distribute the guide and the report prepared pursuant to subsection (b)(2) of this section of the Committee bill to other Federal departments, agencies, and instrumentalities that they carry out such additional research as the Administrator determines is appropriate.

*Paragraph (4) of subsection (b) of section 601* would require the Administrator to review the indexed reference guide periodically and, to the extent the Administrator considers appropriate, to update it based on the results of research completed after the guide was published or other available pertinent information.

*Paragraph (1) of subsection (c) of section 601* would require the President, in order to ensure that any study, research, or other activity carried out by the Federal Government with respect to adverse health effects in humans of exposure to radiation is scientifically valid and is conducted with efficiency and objectivity, to ensure that study under subsection (a)(1)(A) of this section of the Committee bill, the development of the guide required by subsection (b)(1), and any additional research identified pursuant to subsection (b)(2), are fully coordinated with studies or other activities which are planned, are being conducted, or have been completed by other Federal Government entities and which pertain to the adverse health effects in humans from exposure to radiation, including the radio-epidemiological tables mandated by section 7 of the Orphan Drug Act, Public Law 97-414. The President would also be required to ensure that all appropriate coordination and consultation is accomplished between and among the Administrator and the heads of such departments, agencies, and instrumentalities that may be engaged, during the conduct of study under subsection (a)(1)(A) of this section of the Committee bill, in the design, conduct, monitoring, or evaluation of such radiation-exposure studies.

*Paragraph (2) of subsection (c) of section 601* would require the President, not later than 90 days after the date of the enactment of the Committee bill, to submit to the appropriate committees of the Congress a report containing a description of the President's actions to ensure the coordination and consultation required by subsection (c)(1) of this section of the Committee bill.

*Paragraph (1) of subsection (d) of section 601* would authorize the appropriation, for fiscal years after fiscal year 1983, of such sums as may be necessary for the conduct of study under subsection (a)(1)(A) of this section of the Committee bill.

*Paragraph (2) of subsection (d) of section 601* would provide that the authority under subsection (a)(1)(A) of this section of the Committee bill to enter into contracts for the conduct of study shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriations Acts.

*Section 601—Costs:* Enactment of the provisions of section 601 is estimated to entail costs of \$0.6 million in fiscal year 1984. This estimate reflects only the costs of the indexed reference guide under subsection (b) of this section and assumes that study under subsection (a)(1)(A) of this section would be found to be not feasible and would therefore not be conducted.

#### TITLE VII—MISCELLANEOUS AND TECHNICAL AMENDMENTS

##### *Section 701*

Would amend present section 610(a)(3) of title 38, which provides VA hospital and nursing home care eligibility to a person who is in receipt (or but for the receipt of retirement pay would be entitled to) disability compensation, so as to provide for continuing the eligibility for such care of a person who would be entitled to disability compensation pursuant to present section 351 of title 38, providing entitlement to compensation to persons disabled by VA treatment or vocational rehabilitation, but for the fact that payment of compensation to such person has been suspended under section 351 as a result of a judgment or settlement (or but for both such suspension and such person's receipt of retirement pay). Continuing VA health-care eligibility under this provision would exist only to the extent provided for in the judgment or settlement.

*Section 701—Costs:* Enactment of the provisions of section 701 is estimated to entail no significant costs.

##### *Section 702*

*Subsection (a) of section 702* would make a technical amendment to subsection (b) of present section 203 of title 38, relating to the availability of an appropriation for the settlement on a VA construction contract, in order to clarify that an appropriation is available for that purpose only if the settlement both is audited as prescribed in subsection (b) and is provided for specifically in an appropriations law.

*Subsection (b) of section 702* would make a technical amendment to present section 360 of title 38, relating to special consideration for certain cases of blindness or bilateral kidney involvement or bilateral deafness, to move the designator of clause (1) to the beginning of that clause.

*Subsection (c) of section 702* would make a technical amendment to present section 361 of title 38, relating to payment of disability compensation in disability severance cases, to eliminate an unnecessary reference to the United States Code.

*Subsection (d) of section 702* would make a technical amendment to present section 719(b) of title 38, relating to the National Service Life Insurance appropriation, to change a reference to two provisions in the National Service Life Insurance Act of 1940 from "subsections" to "sections".

*Subsection (e) of section 702* would make a technical amendment to clause (C) of present section 1682(c)(1) of title 38, relating to the computation of education assistance allowances for veterans enrolled in an educational institution for a farm cooperative program, to add a comma at the end of the clause.

*Subsection (f) of section 702* would make technical amendments to present sections 2002 and 2002A of title 38, relating to job counseling, training, and placement services for veterans and the position of the Assistant Secretary of Labor for Veterans' Employment, to change the phrase "a Assistant Secretary" to "an Assistant Secretary".

*Subsection (g) of section 702* would make technical amendments to present section 3005 of title 38, relating to joint applications for social security and dependency and indemnity compensation, to replace certain references to title 42 of United States Code (which has not been codified) with references to the Social Security Act.

*Subsection (h) of section 702* would make a technical amendment to present section 4118(g)(3) of title 38, relating to a report on rates of special pay for VA physicians and dentists, to delete an unnecessary comma.

*Subsection (i) of section 702* would make technical amendments to two subsections in present section 4142 of title 38, relating to eligibility for the VA's Health Professional Scholarship Program, to correct a cross-reference in subsection (f)(2) and delete an unnecessary comma in subsection (i)(4).

*Subsection (j) of section 702* would make a technical amendment to subsection (c)(2)(B) of present section 5010 of title 38, relating to limitations on the Administrator's authority to enter into contracts with outside entities for the performance of certain DM&S activities, to reflect Congressional intent (as expressed at the time of the enactment of subsection (c) by section 409(b) of Public Law 97-306) that the Administrator be prohibited from converting the performance of certain activities at VA medical facilities from VA employee performance to contractor performance unless both the quality and quantity (rather than either the quality or quantity) of health-care services provided to veterans at the VA facility involved would be maintained or enhanced.

*Section 702—Costs:* Enactment of the provisions of section 702 is estimated to entail no costs.

#### TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or proxy by members of the Committee on Veterans' Affairs at an April 20, 1983, meeting to consider S. 578.

The committee agreed to report S. 578, with an amendment in the nature of a substitute, favorably to the Senate by a 12-to-0 vote, as follows:

YEAS—12

NAYS—0

Alan Simpson  
Strom Thurmond  
Robert Stafford  
Frank Murkowski  
Arlen Specter  
Jeremiah Denton  
Rudy Boschwitz  
Alan Cranston  
Jennings Randolph

Spark Matsunaga  
Dennis DeConcini  
George Mitchell

#### AGENCY REPORTS

On May 12, 1983, the Veterans' Administration submitted to the Committee on Veteran's Affairs a report on S. 578. In addition the VA submitted reports on S. 567 (dated May 12, 1983), S. 629 (dated May 12, 1983), S. 11 (dated May 13, 1983); and on May 16, 1983, the Office of Personnel Management submitted a report on S. 11; provisions of which are incorporated in S. 578. These agency reports follow:



Office of the  
Administrator  
of Veterans Affairs

Washington DC 20420



Veterans  
Administration

1 MAY 12 1983

Honorable Alan K. Simpson  
Chairman, Committee on  
Veterans' Affairs  
United States Senate  
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the VA on S. 578, as introduced, a bill "To amend title 38, United States Code, to provide for adult day health care services for veterans, to authorize the Veterans' Administration to administer a community residential care program, to establish a presumption of service-connection for former prisoners of war suffering from dysthymic disorder and to revise and clarify eligibility for reimbursement of expenses of travel for Veterans' Administration health care."

S. 578, as introduced, contains four major provisions. First, it would establish a pilot program for the provision of adult day health care services by the VA. VA does not oppose that provision. Second, it would authorize the VA to establish a community residential care program. VA strongly favors that provision. Third, the bill would establish dysthymic disorder (depressive neurosis) as a disability for which service connection could be granted, on a presumptive basis, to former POW's. VA favors that provision. Finally, the bill would impose limitations on VA's beneficiary travel program. This last aspect of the bill has undergone major revision since S. 578 was introduced. The most recent version of the bill would place a cap on amounts which could be spent on the beneficiary travel program and it would direct how all savings resulting from the cap could be spent. VA finds this provision of the bill objectionable.

Title I of the bill would permit the VA to operate through Fiscal Year 1987 a pilot program furnishing adult day health care services at VA medical facilities. Under this measure, such services might be provided as an alternative to institutionalization to any veteran eligible for VA hospital or nursing home care. The scope of adult day health care services would at a minimum include ambulatory medical care provided in a congregate setting. The bill provides as well for including within such programs various modes of therapy, midday meals, social work services, and such medical and rehabilitative services as necessary. The bill calls for

the pilot program to be designed to demonstrate any medical efficacy and cost-effectiveness that may result from furnishing services in such a mode rather than through VA hospitalization or nursing home or domiciliary placement. The measure would authorize the annual expenditure of up to \$35 million to provide these services and to permit any needed leasing, construction, or conversion of facilities.

We have only recently begun an evaluation of the few adult day health care programs that have been initiated at individual VA facilities. This evaluation is aimed at providing data on which program model or models could be effectively used at other VA medical centers. We have no sound basis at this point to determine the cost-effectiveness of operating any of the possible types of adult day health care programs within the VA. Non-VA studies show, however, that adult day health care programs are cost-effective alternatives to institutional care when viewed on a per patient episode of care basis.

The eligibility provisions of chapter 17, title 38, limit the scope of VA's authority to operate such programs. This measure would permit the VA to continue evaluating our limited adult day health care programs, and, if our initial evaluation tended to show their efficacy and cost-effectiveness, to develop this program further under specific authority. We have no objection to the enactment of this provision.

Title II of this bill would provide specific statutory authority for the VA to administer a community residential care program. Under this program, when previously institutionalized veterans request assistance in finding a place to live, the VA refers them to privately operated residential care facilities which provide room, board, personal care, and supervision at the veterans' expense. This measure would authorize the VA to promulgate regulations establishing standards for use in evaluating residential care facilities for purposes of VA-initiated placements.

The VA has a special responsibility to protect the interests of veterans referred to community residential care facilities because of their vulnerability. At present, of the approximately 12,700 veterans in residential care facilities, eighty-seven percent have psychiatric or organic brain diseases. Sixty-three percent are considered incompetent to handle funds. There is no nationwide standard for residential care, and State and local standards, where they exist, are often not enforced. Under this measure, the VA would not regulate these homes. The legislation would affect only those facilities wishing to receive referrals from the VA. A facility's submission to a VA assessment would remain entirely voluntary and its operators would be under no obligation to accept any recommendation by the assessment team. In order to ensure the health and safety of veterans, however, the VA would cease making referrals to noncomplying homes after notice and an opportunity for a hearing. We strongly support this provision.

Title III of the bill would add "dysthymic disorder (or depressive neurosis)" to the list of diseases in subsection 312(b) of title 38 that can be presumed service-connected if suffered by veterans who were held POW at least thirty days. Pub. L. No. 97-37 added "any of the anxiety states" to the list of disorders to be presumed service connected in ex-POW's. It followed extensive congressional inquiry into the increased incidence of mental health disorders among ex-POW's. This provision is a logical extension of Pub. L. No. 97-37. No one can deny the severity of psychological stressors to which American ex-POW's were, as a group, subjected.

Additional practical considerations also support enactment of this proposal. Difficulties of diagnosis are presented by the fact that depressive features may exist in a number of disorders with discrete diagnostic classifications, including some of the anxiety states. It is, therefore, not unusual that the diagnosis of a patient's illness will vary somewhat over time, or from examiner to examiner. By permitting VA

to presume service connection for dysthymic disorders as well as the anxiety states, the adjudication of claims will be simplified and the dangers of error resulting from incorrect diagnoses minimized. We favor this proposal.

To this point, we have confined our comments on S. 578 to the bill as it was introduced. Since introduction, however, it has undergone substantial revision. The provisions of the bill limiting beneficiary travel payments have been substantially altered. Under the original bill, savings would be achieved in the program by imposition of a \$10 deductible on most beneficiary travel payments. Under title III of the most recent version of the bill, cost savings would be achieved by capping beneficiary travel expenditures from the medical care account at the fiscal year 1983 level. Savings of at least \$20 million are anticipated in the bill. The bill directs that the Administrator issue regulations to achieve savings in the current program sufficient to reduce expenditures below the cap. The bill also allows VA to continue the regulations beyond one year to continue achieving savings in the program beyond fiscal year 1984.

Title III of the most recent version of the bill also directs the Administrator to expend at least \$20 million, in addition to amounts already budgeted for community nursing home care, on the new adult day health care program and the new preventive health care program, both authorized by the bill, as well as on community nursing home care. It requires several reports to the Senate and House Veterans' Affairs Committees, as well as the Comptroller General, so that they can monitor the VA's compliance with the requirements of the law. The bill also provides that if the Comptroller General finds that VA has not fully complied with the law during fiscal year 1984, the authority to continue the regulations achieving savings in the beneficiary travel program would be automatically repealed at the end of fiscal year 1984.

We find several requirements contained in title III of the bill to be highly objectionable, especially the concept of Congress directing how monies saved in the beneficiary travel program be expended. In addition, the provision automatically repealing the Administrator's authority to

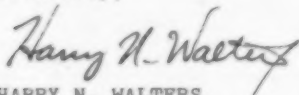


continue cost savings regulations beyond fiscal year 1984 assumes that that official would not comply with the law, an assumption we find unwarranted. Finally, we do not believe the extensive congressional reporting requirements imposed on the VA to monitor compliance with the law are justified.

Although title I of S. 578, as it was introduced, authorizes expenditures of \$35.0 million per year for four fiscal years, our proposed implementation would impose costs of only \$27.7 million over four fiscal years. Title II, which authorizes creation of a community residential care program would not impose new costs on the VA. Title III, which makes dysthymic disorder a presumptive disability for POW's, would impose costs of \$10.5 million over five fiscal years. Finally, the provision of the bill which places a cap on expenditures for the beneficiary travel program would neither impose new costs, nor result in cost avoidance since all savings which would be achieved by imposing the cap are directed to be spent on other programs.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

A handwritten signature in dark ink, appearing to read "Harry N. Walters", with a stylized flourish at the end.

HARRY N. WALTERS  
Administrator

Office of the  
Administrator  
of Veterans Affairs

Washington DC 20420



**MAY 12, 1983**

Honorable Alan K. Simpson  
Chairman, Committee on Veterans' Affairs  
United States Senate  
Washington, D.C. 20510

Dear Mr. Chairman:

We are pleased to respond to your request for the views of the Veterans Administration on S. 567, 98th Congress, a bill "To amend title 38, United States Code, to authorize reimbursement for the reasonable charge for chiropractic services provided to certain veterans."

Based on professional, programmatic, budgetary concerns, we oppose enactment of this bill.

In essence, S. 567 would require the VA to establish a pilot program for providing chiropractic care to VA beneficiaries. The bill would direct the VA's Administrator, under regulations prescribed by the Administrator, to pay reasonable charges for chiropractic services furnished veterans eligible for VA medical care who meet one of the following conditions:

1. The chiropractic treatment is for a service-connected neuromusculoskeletal condition of the spine;
2. The veteran had been furnished hospital care by the VA for a neuromusculoskeletal condition of the spine within the 12 months preceding the rendering of the chiropractic services; or
3. The veteran has a service-connected disability rated at 50 percent or more, and has previously been furnished care by the VA for a neuromusculoskeletal condition of the spine, but only to the extent that payment for the chiropractic services are not otherwise reimbursed.

Reimbursements would be made in accordance with a schedule of charges established by the Administrator in consultation with other Federal agencies and public and nonprofit organizations that reimburse for chiropractic services. The proposed VA schedule of reasonable charges is to be "consistent" with the reasonable charges allowed under the Medicare program. The

reimbursements to individual veterans authorized by S. 567 could not exceed \$600 per year, and the overall appropriation authorized by this bill is \$2 million per fiscal year. Unless later extended, no reimbursement under the bill's program could be made after September 30, 1987. The bill requires that the Administrator submit, by December 31, 1984, and by that date in each year thereafter, a report to the Congressional Committees on Veterans' Affairs on the results of his actions in implementing the bill.

This bill presumably is based on the premise that the VA lacks the ability to give the full range of quality medical care to eligible veterans. We reject that premise. The VA is required by law to provide a complete hospital and medical service for the care of veterans and to employ the services of licensed physicians who hold a degree of doctor of medicine or osteopathy from a college or university approved by the Administrator. The therapeutic capabilities of the existing VA medical staffs and consultants are comprehensive and flexible, and fully meet the needs of all veteran patients. We strongly believe that disorders of the musculoskeletal system are skillfully treated by our Orthopedic and Rehabilitation Medical Services and existing support personnel.

Enactment of S. 567 would create the undesirable precedent of permitting patient entry into the VA health care system without prior VA authorization and determination as to a veteran's need for treatment. We oppose as both fiscally wasteful and highly questionable from a therapeutic standpoint any open-ended system which would authorize the Government to pay bills for chiropractic services determined necessary only by the veteran himself or the chiropractor. We generally look to orthopedic surgeons, neurosurgeons, neurologists or physiatrists, rather than to chiropractors, to diagnose and treat eligible veterans afflicted with neuromusculoskeletal conditions of the spine. Physical therapists, working under the supervision of such physicians, are also utilized by the VA in this endeavor. We note that, under existing authority, a treating VA physician may refer a veteran eligible for VA medical treatment to a chiropractor for treatment on a fee basis. Concededly, this authority is seldom, if ever, used. This bill, however, would create the questionable precedent

of authorizing fee-basis services for veterans without any initial determination by VA as to the need for the services. The VA, under S. 567, would be given the responsibility to pay for chiropractic services while having no role whatsoever in determining the need for treatment.

From both a health care and a fiscal perspective, it is our position, accordingly, that a veteran eligible for VA medical care for a neuromusculoskeletal condition of the spine who nevertheless presents himself to a chiropractor (or even to a private physician) without having been referred by the VA, should not be entitled to reimbursement.

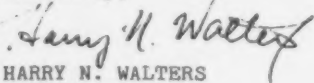
We note that we would not characterize chiropractic as "medical treatment." The proposed establishment of the bill's program as a new section 630 in chapter 17 in title 38, United States Code, however, would raise the question whether a veteran injured as a result of services rendered by a VA-reimbursed chiropractor has suffered an injury as the result of "medical or surgical treatment" within the meaning of 38 U.S.C. § 351 so as to be eligible for section 351 compensation benefits. An affirmative answer to that question could entail long-term indirect costs to the VA associated with the enactment of S. 567.

Moreover, we believe that VA would experience a very considerable administrative burden in reimbursing each veteran's or chiropractor's claim under the bill. Extensive processing would be required to meet the bill's conditions for reimbursement.

Based on the foregoing, we strongly oppose this legislation.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,



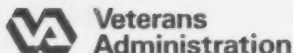
HARRY N. WALTERS  
Administrator

Enclosure



Office of the  
Administrator  
of Veterans Affairs

Washington DC 20420



MAY 12 1983

Honorable Alan K. Simpson  
Chairman, Committee on Veterans' Affairs  
United States Senate  
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the Veterans Administration on S. 629, 98th Congress, a bill "To amend title 38, United States Code, to increase the per diem rate payable by the Veterans' Administration to States providing domiciliary, nursing home, and hospital care to veterans in State homes."

The proposed legislation would increase the specific per diem rates prescribed in 38 U.S.C. § 641 to be paid by the Veterans Administration to State domiciliaries, nursing homes, and hospitals for the care of veterans eligible for this care in a VA facility. These rates would be increased by about 15 percent for each level of care: from \$6.35 to \$7.30 for domiciliary care, from \$12.10 to \$13.95 for nursing home care, and from \$13.25 to \$15.25 for hospital care. These higher rates would become effective on October 1, 1983 unless the increase in Social Security benefits scheduled for June 1, 1983 is delayed by reason of a law enacted in 1983. In this case, the effective date of these rates would be delayed beyond October 1, 1983, by the same number of months as the Social Security benefits increase is delayed. Since it was never intended that State home per diem payments would result in the VA funding a certain percentage of the cost of care of these facilities, we oppose the bill's enactment.

The State home program has long been recognized as a vital resource for meeting the extended care needs of our aging veteran population. Current VA planning anticipates continued growth in the State home program to help meet the increased future demand for extended health care of the aging veteran population. The program began on August 27, 1888, with an act to provide aid to State or territorial homes for States. In 1939, the law was amended to extend assistance to hospital care provided in State homes. In 1964, Public Law 88-450 extended Federal assistance to State homes to include nursing home care, and separate per diem payments were established for each level of care: namely, domiciliary, nursing home, and hospital care. In Fiscal Year 1982, VA

per diem payments to State veterans homes for domiciliary care totalled approximately \$10.4 million. Additionally, the VA offers funding of up to 65% of the cost of constructing State home facilities. In Fiscal Year 1982, \$11.4 million was obligated for construction purposes.

I wish to express again the strong commitment of the Veterans Administration to providing assistance to State homes and to working closely with them for the care and welfare of our veterans. However, our budget for Fiscal Year 1984 does not provide for an increase in State home per diem rates. Enactment of S. 629 would thus adversely affect our ability to maintain existing program commitments to veteran beneficiaries. We do intend, however, to consider the desirability of a rate increase in formulating our budget for the 1985 Fiscal Year.

We estimate the cost to the Veterans Administration of enacting S. 629 would be as follows:

| <u>FISCAL YEAR</u> | <u>COST (in millions)</u> |
|--------------------|---------------------------|
| 1984               | \$ 6.9                    |
| 1985               | 7.1                       |
| 1986               | 7.3                       |
| 1987               | 7.5                       |
| 1988               | <u>7.6</u>                |
| TOTAL              | \$36.4                    |

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,

*Harry N. Walters*

HARRY N. WALTERS  
Administrator

Cost Estimate  
H.R. 1645 - 98th Congress 2nd Session

|                               | <u>Estimated<br/>ADC</u> | x | <u>Increase in Cost</u> | x | <u>Days</u> | = | <u>Estimated<br/>Cost</u> |
|-------------------------------|--------------------------|---|-------------------------|---|-------------|---|---------------------------|
| <u>STATE HOME DOMICILIARY</u> |                          |   |                         |   |             |   |                           |
|                               |                          |   | (\$6.35 to \$9.50)      |   |             |   |                           |
| 1984                          | 5077                     |   | 3.15                    |   | 366         |   | 5,853,273                 |
| 1985                          | 5312                     |   | 3.15                    |   | 365         |   | 6,107,472                 |
| 1986                          | 5479                     |   | 3.15                    |   | 365         |   | 6,299,480                 |
| 1987                          | 5509                     |   | 3.15                    |   | 365         |   | 6,333,973                 |
| 1988                          | 5658                     |   | 3.15                    |   | 366         |   | 6,523,108                 |
|                               |                          |   |                         |   |             |   | <u>31,117,306</u>         |

|                           |      |  |                      |  |     |  |                   |
|---------------------------|------|--|----------------------|--|-----|--|-------------------|
| <u>STATE HOME NURSING</u> |      |  | (\$12.10 to \$16.00) |  |     |  |                   |
| 1984                      | 6927 |  | 3.90                 |  | 366 |  | 9,887,600         |
| 1985                      | 7187 |  | 3.90                 |  | 365 |  | 10,230,695        |
| 1986                      | 7390 |  | 3.90                 |  | 365 |  | 10,519,665        |
| 1987                      | 7589 |  | 3.90                 |  | 365 |  | 10,802,942        |
| 1988                      | 7749 |  | 3.90                 |  | 366 |  | 11,060,923        |
|                           |      |  |                      |  |     |  | <u>52,501,825</u> |

|                             |     |  |                      |  |     |  |                  |
|-----------------------------|-----|--|----------------------|--|-----|--|------------------|
| <u>STATE HOME HOSPITALS</u> |     |  | (\$13.25 to \$16.90) |  |     |  |                  |
| 1984                        | 590 |  | 3.65                 |  | 366 |  | 788,181          |
| 1985                        | 590 |  | 3.65                 |  | 365 |  | 786,028          |
| 1986                        | 590 |  | 3.65                 |  | 365 |  | 786,028          |
| 1987                        | 590 |  | 3.65                 |  | 365 |  | 786,028          |
| 1988                        | 590 |  | 3.65                 |  | 366 |  | 788,181          |
|                             |     |  |                      |  |     |  | <u>3,934,446</u> |

| <u>Summary</u> | <u>Domiciliary</u> | <u>Nursing Home</u> | <u>Hospital</u> | <u>Total</u>      |
|----------------|--------------------|---------------------|-----------------|-------------------|
| 1984           | \$ 5,853,273       | \$ 9,887,600        | \$ 788,181      | \$16,529,054      |
| 1985           | 6,107,472          | 10,230,695          | 786,028         | 17,124,195        |
| 1986           | 6,299,480          | 10,519,665          | 786,028         | 17,605,173        |
| 1987           | 6,333,973          | 10,802,942          | 786,028         | 17,922,943        |
| 1988           | <u>6,523,108</u>   | <u>11,060,923</u>   | <u>788,181</u>  | <u>18,372,212</u> |
| TOTAL          | \$31,117,306       | \$52,501,825        | \$3,934,446     | \$87,553,577      |

Concurrence 10A2

*J. D. King*

Office of the  
Administrator  
of Veterans Affairs

Washington DC 20420



MAY 13 1983

Honorable Alan K. Simpson  
Chairman, Committee on  
Veterans' Affairs  
United States Senate  
Washington, D.C. 20510

Dear Mr. Chairman:

I am pleased to respond to your request for the views of the VA on S. 11, a bill "To amend title 38, United States Code, to establish a Veterans' Administration Advisory Committee on Women Veterans; to improve various aspects of Veterans' Administration health-care programs; to extend the period for Vietnam-era veterans to request counseling under the Veterans' Administration Readjustment Counseling Program; to promote the recruitment and retention of certain health-care personnel in the Veterans' Administration's Department of Medicine and Surgery; to express the sense of the Congress with respect to the role of the Administrator of Veterans' Affairs; to require the Administrator of Veterans' Affairs to conduct an epidemiological study of long-term health effects in veterans of exposure to ionizing radiation from nuclear test detonations; and for other purposes."

S. 11 contains six titles, each involving a distinct subject matter. Among its provisions, title I would extend the Vietnam era back from the present August 5, 1964 to July 8, 1959. VA does not oppose this provision. Title II would mandate creation of an Advisory Committee on Women Veterans, and it would give VA authority to provide outpatient gender-related care to women veterans on a fee basis. VA opposes both of these provisions. Title III would extend by one year, to September 30, 1985, the final date by which veterans must apply for readjustment counseling benefits. We cannot support such an extension because it would be premature to do so at this time. Title III would also authorize VA to provide preventive health-care services, and it would mandate creation of a program to provide such services. VA favors the measure to the extent it provides authority to provide services, but we oppose the mandate that a program be created. Title IV would convert licensed practical nurses, respiratory therapists, and physical therapists from title 5 employees to title 38 employees. The VA defers on this issue to the Office of Personnel Management. Title V expresses the sense of Congress that the Administrator



of Veterans' Affairs should be a member of the President's cabinet. VA defers to the President on the question of enactment of this provision. Finally, title VI would mandate that the VA conduct an epidemiological study and literature review of the health effects on veterans resulting from their exposure to ionizing radiation during weapons tests and during the occupation of postwar Japan. VA opposes these provisions.

A number of benefits administered by the VA are provided only to veterans who served during a period of war. Currently, all service between August 5, 1964 and May 7, 1975, wherever served, is considered to be service during the Vietnam War. Section 101 of this bill would lengthen the period of time considered to be Vietnam War service to include individuals who served in the Republic of South Vietnam between July 8, 1959 and August 5, 1964.

Veterans covered by this provision would become potentially eligible for several benefits. Principally, they could receive nonservice-connected pension benefits if they also meet disability, income, and net worth requirements. Other benefits they might receive include certain burial benefits, readjustment counseling services, loan guaranty benefits in certain cases, and certain education, on the job-training, or apprenticeship benefits for educationally disadvantaged, unskilled, or unemployed veterans.

VA believes this is an appropriate change in the law. We estimate that a maximum of 48,000 veterans served in Vietnam between July 8, 1959, the date of the first American military casualty, and August 5, 1964, the date of the Gulf of Tonkin Resolution. Those veterans served under adverse conditions which can be considered akin to wartime conditions. It is reasonable that they be eligible to receive those benefits for which wartime service is a requirement.

In connection with home loan benefits, it should be noted that under section 1802(a), veterans of the Vietnam era are eligible for such benefits if their total service was for 90 days or more, or they were discharged or released for a service-connected disability. Under section 1818, veterans who served between February 1, 1955 and August 4, 1964, are eligible for housing loan benefits if they served on active duty for 181 consecutive days, or were released from active duty for a service-connected disability. We consider it unlikely that any veteran who had actual service in Vietnam between July 8, 1959 and August 4, 1964, served on active duty for less than 181 continuous days, unless they were discharged or released for a service-connected disability.

Nevertheless, in view of this proposed expanded definition of the Vietnam era, we would recommend that a conforming amendment be made to section 1818 of title 38 to make it clear that persons who would become Vietnam era veterans as a result of this amendment need only 90, rather than 181, days of service in order to qualify for housing loan benefits.

Section 201 of the bill, if enacted, would require the Administrator of Veterans Affairs to establish and maintain, until terminated by law, an advisory committee on women veterans. It would mandate the appointment from among members of the general public of representatives of women veterans, authorities on the health care and other needs of women veterans, and representatives of male and female veterans with service-connected disabilities. The bill would also require the appointment, as ex-officio members, of two persons who are now members of the DoD advisory committee on women, and the Chief Medical Director and Chief Benefits Director or their designees. The measure would limit any appointee's term of service to a three-year period. It would require that the committee meet at least four times annually, and that the Administrator consult with, and seek the advice of, the committee on a regular basis. Further, the committee would be required annually to furnish the Administrator with a report, including recommendations, on VA programs and needs pertaining to women veterans. The Administrator would be required to submit each report to Congress.

In essence, the bill seeks to codify a decision which is more appropriately left to administrative discretion and which, in fact, has already been made within the VA. Additionally, provisions of the bill are, in our view, unnecessarily restrictive and may hinder our efforts to accomplish the bill's purpose.

We agree in principle with what appears to be the major purpose underlying this provision--the desirability of providing the Administrator a broad spectrum of views to assist the Agency in planning to meet the needs of women veterans. However, we cannot agree with the premise that

legislation is necessary or desirable to accomplish this. The Administrator of Veterans Affairs has broad authority to obtain advice and assistance in planning and administering the Agency's programs. In fact, shortly after his confirmation, the Administrator directed VA Department heads to take steps to facilitate the administrative establishment of an advisory committee on women veterans. A measure such as this, which mandates the establishment, mission, general composition, duration, reporting requirements, and mode of operation of an advisory committee, deprives the Agency of the discretion and flexibility so important to sound program administration.

In summary, we oppose this provision because we believe it unnecessarily restricts the Administrator's discretion to administer programs entrusted to his care and represents a mechanism which, in its rigidity, could actually prove a greater burden than a benefit. Moreover, it is unnecessary in light of administrative actions already taken.

Section 202 of this bill would also amend 38 U.S.C. § 601(4)(C)(iv) to permit the VA to provide female veterans with fee-basis out-patient care to obviate a need for hospitalization for nonservice-connected gender-related conditions. VA attaches a high priority to providing comprehensive health care to female veterans that is comparable to the care furnished to male veterans. We have made significant strides in improving our capability for treating women veterans, including the provision of outpatient care for gender-related disorders. Among those steps was the recent publication of a VA Circular (10-83-14)--Health Care for Female Veterans. The circular--directed to our health care facilities--emphasizes the high priority which should be given to provision of health care services for female veterans.

The circular directs each medical center and outpatient clinic to review its method of providing outpatient gynecologic services. It further directs that those needing improvement upgrade this capability by June 1, 1983. The circular provides that in-house capability for providing the services is preferable, but that alternatives may include the use of consultants as needed, or in regularly scheduled clinics, referral of women to other VA medical centers, and agreements with affiliated hospitals or DoD installations. This could

include contracting for the services of gynecologists under the provisions of sections 4117 or 5053 of title 38. We believe our efforts towards establishing a capability to provide in-house services to female veterans make this provision of the bill unnecessary.

To enact this measure would also add to the U.S. Code a provision which is not only unnecessary but which, on its face, differentiates between veterans on the basis of gender. It would permit a nonservice-connected female veteran, but not a male, to obtain treatment at VA expense from a private physician for a gender-related disorder when VA facilities are geographically inaccessible or cannot provide needed services. Its enactment would thus run counter to this Administration's policy of ridding the U.S. Code of provisions which unjustifiably differentiate or effectively discriminate on the basis of sex.

We are deeply committed to meeting the needs of women veterans and believe the actions we have taken administratively demonstrate that there is no need for the enactment of this provision of the bill.

Section 301 of the bill would extend, by one year, until September 30, 1985, the period within which a veteran must make an initial request to be eligible for readjustment counseling services. It would also extend by one year, to the end of fiscal year 1984, the period during which the Administrator must take steps to ensure orderly transition of the program to one providing counseling through VA Medical Centers, rather than the Vet Centers.

In essence, although we support the intent of section 301, we cannot support an extension of the readjustment counseling program at this time. We have recently established an Agency task force which is examining readjustment counseling activities, and it would be premature to express or attempt to formulate a position on this issue until after the task force has reported its findings.



The VA recognizes the value of the readjustment counseling program and is strongly committed to it. It should be noted that those Vietnam-era veterans who have requested readjustment counseling services before September 30, 1984, and continue to need those services after that date remain eligible under the law. The mechanisms by which those services will be provided after that date have not yet been established. Although we have formed an Agency task force to address the many issues raised by that statutory mandate, we have experienced a continuing increase in the counseling workload which suggests there remains an unmet need. Our efforts to plan for the future of this program are still at a relatively early stage. Any attempt to extend readjustment counseling eligibility should be deferred until after the task force's ultimate findings and the recommendations of the Chief Medical Director are made. Although the numbers of additional Vietnam-era veterans who might seek these services for the first time after September 1984 may not be large, this program has demonstrated its capacity to provide needed assistance. If we are to continue to be responsive to the needs of the veterans we serve, we must constantly look to improve our methods of service delivery. Through our study of readjustment counseling activities, we would be able to better decide what is the most effective and efficient way to provide this service. For these reasons, it is important that any extension legislation be deferred for the time being.

Section 302 of the bill would amend recently enacted provisions which authorize a preventive health care services pilot program in the VA. Instead of the pilot program, this bill would require the creation of a permanent preventive health care program involving both the provision of services to certain service-connected veterans and research studies to determine the efficacy and cost-effectiveness of providing such services. The measure would also expand the definition of "medical services" in title 38 to permit the Agency to furnish preventive health-care services to veterans who are otherwise receiving VA care or treatment.

VA recognizes, professionally, the value of a preventive focus in the delivery of health care. There is evidence that, in certain patient populations, particular preventive health-care services are efficacious and can conceivably result in medical care cost savings in the long run. Therefore, we do not object to the proposed amendment to section 601(6) of title 38 to the extent that it would authorize VA to provide appropriate preventive services

as an element of good medical treatment to patients otherwise receiving VA care. We would not intend, however, to use that authority to provide at large the wide range of services listed in section 662 of title 38. And although we see merit in the proposed discretionary authority in section 302(a) of the bill, we oppose section 302(b) which would amend sections 661 and 663 of title 38 to mandate a preventive health care program.

Similarly, we oppose the provision of the bill which mandates large scale followup studies and research on the effectiveness of a preventive health-care program. VA research projects are initiated at the local facility level and they are funded by Central Office. Currently, several projects are underway in various medical centers to determine the efficacy of certain types of preventive health-care services. We oppose the mandatory study provision because we believe it would interfere with the existing process which allows all research projects to compete, on their merits, for limited research dollars.

Section 501 of the bill would, if enacted, express the sense of the Congress that the Administrator of Veterans Affairs should be a member of the President's cabinet. It does not mandate that the President designate the Administrator as a member of his cabinet.

The VA is responsible for the administration of the laws providing benefits to our Nation's veterans. In that regard, we provide medical care and treatment, compensation and pension benefits, education benefits, loan guarantees, insurance, and burial benefits. As part of this responsibility, the VA necessarily acts as the principal advisor to the President on matters related to veterans' affairs. The Administrator, as the head of the Agency, exercises great influence within the Government on national policies related to veterans. At the present, the Administrator works closely with officials at the highest level of Government on matters related to veterans' affairs. Generally, that has been true in the past. However, the VA defers to the President on this provision.

Section 601 would require an epidemiological study of service-members exposed to ionizing radiation as test participants or occupation forces. The study is to be of possible long-term adverse health effects, including psychological effects, in exposed veterans and genetic and congenital problems of their natural children. It would be conducted by an outside person or agency other than the Departments of Defense and Energy, and coordinated with other Federal research efforts. There would be a timetable for reports to Congress on the progress of the study.

We believe that a mandated study is not needed. Steps have already been taken to investigate whether such a study could and should be conducted. At a recent meeting of the Inter-agency Radiation Research Committee (IRRC), which was established in 1980 in part as a clearinghouse for Federal radiation research efforts, VA described the concept of conducting an epidemiological study. We will be advised of the Committee's conclusion as to the scientific advisability and feasibility of a comprehensive study of test participants and veterans present in Hiroshima and Nagasaki as occupation forces. The importance of coordinating Government research in this area was emphasized in a 1981 GAO report (EMD-81-1) to ensure studies are of sufficient scientific merit to justify their costs. We will proceed with plans for an epidemiological study if, in the view of the scientific experts who advise and comprise the IRRC, it would yield scientifically useful results.

A second aspect of section 601 would impose on the VA the duty to "conduct a comprehensive review of scientific analysis of the literature" on adverse health effects in humans of exposure to radiation from all sources. We appreciate the Committee's concern that the significant body of scientific literature on this subject be compiled in an orderly manner. However, for several reasons, we believe legislation to effectuate this purpose is unnecessary. We have entered an agreement with the National Library of Medicine to provide us with a compilation of literature searches as they have done previously and, more importantly, to furnish a monthly update of newly published articles. We have already received the computer literature print-outs on low-level radiation effects for the last 40 months, through April of 1983. We anticipate that the monthly update will form the basis for us to determine whether the results of new research would be valuable information to be disseminated to employees performing adjudicative or patient-treatment functions within the Agency.

The scientific literature available on radiation is massive. The 1981 GAO Report mentioned that there have been more than 80,000 internationally published articles on the health effects of ionizing radiation, and a substantial number have been added to the vast literature since then.

To the extent that a literature review would be a background tool for future investigations, I can report that several such reviews already exist and are widely available for ready reference. Under the aegis of the United Nations Scientific Committee

on the Effects of Atomic Radiation (UNSCEAR), seven reports have been issued since 1958, each consisting in part of comprehensive bibliographies of the scientific literature. Similar reports, also containing bibliographies, have been issued by the National Academy of Sciences (NAS) Committee on the Biological Effects of Ionizing Radiation (BEIR), the most recent having been issued in 1982. The National Research Council's Federal Research on the Biological and Health Effects of Ionizing Radiation (FREIR) report also discusses research in this area. For the VA to embark upon its own literature review at this juncture would be a duplication of the efforts of these respected bodies, and would not offer any significant advantage over what is currently accessible.

Section 602 focuses on provision of benefits and services for veterans or their natural children who have genetic or congenital disabilities where disabilities may be related to veterans' exposure in service to ionizing radiation from the detonation of a nuclear device, dioxin from herbicides used in Vietnam, or other toxic substances. The VA would be required to recommend, before the completion of research on the effects of exposure, alternative approaches to the handling of these potential disabilities.

We see no need for alternatives to current VA programs to benefit veterans who may suffer adverse health effects as a result of exposure to hazardous substances. The whole panoply of VA benefits, available to service-disabled veterans generally, is available to these individuals; in fact, more generous health-care eligibility exists for certain of them by reason of section 102 of Pub. L. No. 97-72.

The controversies that attend the issues of veterans' exposure to hazardous substances are not grounded in the adequacy of available benefits and services or mechanisms for their delivery so much as in the scientific evidence regarding dosage, cause and effect. The latter inquiries would not be advanced by this required report.

We understand the concern expressed, at the time the bill was introduced, that the Congress should be prepared to act swiftly if a causal relationship between exposure and genetic or congenital defects is ever demonstrated. However, two countervailing considerations lead us to oppose this aspect of the bill.



The first flows from the practical problems of hypothetical analysis. Without knowing what, if any, disablement would be at issue, one cannot fashion an appropriate remedy let alone know the advantages or disadvantages of various alternatives.

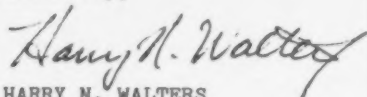
Second, and more important, is that any value to Congress in having alternative proposals at its ready disposal would be more than offset by the anxiety engendered in the community that the causal relationship hypothesized in such publicly made proposals actually exists. At present, there is no scientific evidence of increased likelihood of birth defects in later-born offspring of veterans exposed to these substances in service, and in the case of ionizing radiation, for example, the weight of the evidence is that genetic or congenital defects in children do not result from low-level exposure. Even the studies of the Japanese exposed at Hiroshima and Nagasaki to large amounts of radiation failed to show signs of genetic effects on children. Ongoing and proposed research may yield more definitive data, but those results are years away and would be entirely speculative at this point. Nonetheless, a certain number of afflicted children have been and will continue to be born to veterans, giving rise to questions about a cause and effect relationship with military service. Public consideration by Congress of methods of providing for redress of genetic or congenital disabilities would lend the unwarranted appearance that a scientific link is soon to be established and quite possibly would increase the anxiety of parents and parents-to-be, regardless of the existing negative evidence. We are concerned about this and believe it preferable that we forestall needless suspicions and fears. Consequently, we oppose section 602 as premature.

VA is unable to estimate the costs of all of the provisions of S. 11 and cannot, therefore, give a total cost estimate for the bill. Title I, which extends the length of the Vietnam era, would not generate significant costs. Title II, which relates to women veterans would, potentially, impose some additional costs to the VA, but there is no basis to determine the amount. Section 301 of title III, the extension of the date within which veterans may seek readjustment counselling will impose additional costs of some \$31.4 million in fiscal year 1985. Section 302 of title III, which

mandates a preventive health care program would impose costs of \$93.5 million over five fiscal years. Title IV, which would convert certain employees to title 38 employees, would impose costs of \$46.5 million over five fiscal years. Title V, regarding cabinet status for the Administrator, would impose no additional costs. Finally, we are unable to estimate the costs of title VI of the bill which mandates the conduct of an epidemiological study. The costs of such a study are entirely dependent on the scope of the study to be undertaken and that cannot be determined until a protocol for the study has actually been developed. However, we expect the costs to be at least \$10 million and as high as \$40 million. The methodology for determining the costs is enclosed in this report.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report from the standpoint of the Administration's program.

Sincerely,



HARRY N. WALTERS  
Administrator

Enclosure

SUMMARY - COST ESTIMATES.II

|                                            | <u>FY 84</u>                                                 | <u>FY 85</u>      | <u>FY 86</u>    | <u>FY 87</u>    | <u>FY 88</u>    |
|--------------------------------------------|--------------------------------------------------------------|-------------------|-----------------|-----------------|-----------------|
| <u>Title I - Sec 101</u>                   | No additional DM&S cost.                                     |                   |                 |                 |                 |
| <u>Title II</u>                            |                                                              |                   |                 |                 |                 |
| *Sec 202 - Contract<br>Care-Women Vets     | Potential for increase, however, no basis for make estimate. |                   |                 |                 |                 |
| <u>Title III</u>                           |                                                              |                   |                 |                 |                 |
| Sec 301 - Vet Center<br>Extension:<br>FTEE | -                                                            | \$ 31.4M*<br>552* | -               | -               | -               |
| Sec 302 - Preventive<br>Health Care        |                                                              |                   |                 |                 |                 |
| Expand Hyper.<br>Screening<br>FTEE         | \$ 3.1M<br>70                                                | \$ 7.3M<br>140    | \$ 12.6M<br>210 | \$ 18.9M<br>250 | \$ 25.3M<br>350 |
| Other Projects<br>FTEE                     | \$ 1.4M<br>28                                                | \$ 1.4M<br>28     | \$ 1.4M<br>28   | \$ 1.4M<br>28   | \$ 1.4M<br>28   |
| Research<br>FTEE                           | \$ 2.5M<br>78                                                | \$ 4.2M<br>138    | \$ 4.2M<br>138  | \$ 4.2M<br>138  | \$ 4.2M<br>138  |
| <u>Title IV</u>                            |                                                              |                   |                 |                 |                 |
| Sec 401-411<br>Title 38<br>Conversion      | \$ 9.3M                                                      | \$ 9.3M           | \$ 9.3M         | \$ 9.3M         | \$ 9.3M         |
| TOTALS                                     | \$ 16.3M                                                     | \$ 53.6M**        | \$ 27.5M        | \$ 33.8M        | \$ 40.2M        |
| Total FTEE                                 | 176                                                          | 858***            | 376             | 446             | 516             |

\*No additional cost or FTEE; already in 1984 base.

\*\*\$31.4 already in 1984 base.

\*\*\*552 FTEE already in 1984 base.



Veterans  
Administration

Date: March 1, 1983

To: Resource Management (10A2A2)

# Memorandum

From: Director, Medical Service (111)

Subj: Hypertension Prevention Medicine  
Clinics

## METHODS USED TO DETERMINE COSTS:

There are already in existence 32 Hypertension Screening and Treatment Clinics, operating in the same format as proposed. From the experience gained over the last 10 years, the one change proposed for this document is the reduction from a full time to a half time physician coordinator.

### Salaries:

|   |                                              |          |
|---|----------------------------------------------|----------|
| 1 | 0.5 physician at Chief/10. . . . .           | \$34,150 |
| 2 | RN's or PA's @ R22,956 (Full 38/5) . . . . . | 45,912   |
| 1 | Clerk GS-5/5 . . . . .                       | 15,153   |

For 20 VAMC's . . . . . \$1,904,300

### Recurring Supplies:

\$5,000 per year per clinic

For 20 VAMC's . . . . . \$100,000  
(This includes basic supplies plus  
teaching aid for patients)

### Non-Recurring Supplies:

Each VAMC \$2,500 for 20 VAMC's . . . . . \$ 50,000  
(This is for minor construction plus  
basic equipment such as examining  
tables, otoscopes, sphygmomanometers,  
desks, etc.)

Based on the assumption that each clinic will have 200 patients under treatment the first year to a maximum of 800 patients in 4 years, the cost would be as follows:

200 x \$47.00 laboratory fees = \$9,400 X 20 . . . . \$188,000

200 X \$225.00 for medication costs = \$45,000 X 20 ..\$900,000

JOHN J. CASTELLOT, SR., M.D.  
Director, Medical Service



HYPERTENSION CLINICS  
FOR PREVENTIVE MEDICINE

Estimated Cost of Activating 20 Hypertension Screening & Treatment  
Clinics Each Year During FY 1984-1988 (5 Years)

|             | 84        | FTE | 85        | FTE | 86         | FTE | 87         | FTE | 88         | FTE |
|-------------|-----------|-----|-----------|-----|------------|-----|------------|-----|------------|-----|
|             |           | 70  |           | 70  |            | 70  |            | 70  |            | 70  |
| Incremental | 3,142,300 |     | 4,180,300 |     | 5,268,300  |     | 6,356,300  |     | 6,356,300  |     |
| Cumulative  | 3,142,300 | 70  | 7,322,600 | 140 | 12,590,900 | 210 | 18,947,200 | 280 | 25,303,500 | 350 |

Personnel each clinic \$95,215.00      Drugs 600 pts.      Drugs - 1200 pts.      Drugs - 2000 pts.      Drugs - 2800 pts.  
Lab Fees 600 pts.      Lab Fees 1200 pts.      Lab Fees 2000 pts.      Lab Fees 2800 pts.

Non-Recurring \$2,500.00/Clinic in year 1

Recurring \$5,000.00/Clinic/year

Drugs 200 patients /Clinic inc/year to 800/clinic  
\$900,000  
Lab Fees

200 patients/clinic/increase/year to 800/clinic  
\$188,000

\*See covering memo

## COST ESTIMATE FOR S.11

## VETERANS' PROGRAMS IMPROVEMENT ACT OF 1983

FEBRUARY 11, 1983

## I. Section 403: Cost of Board Actions for Initial Conversion

Assumptions:

- o Professional Standards Boards will review 8,900 LP/LVN's, 678 PT's, and 200 RT's.
- o Each board review requires 1/2 hour.
- o Hourly cost for a board is \$76.77 computed as follows:

| <u>Member</u>               | <u>Hourly Rate</u>                                       |
|-----------------------------|----------------------------------------------------------|
| GS-13/5                     | \$19.03                                                  |
| GS-12/5                     | 16.00                                                    |
| GS-11/5                     | 13.35                                                    |
| GS-11/5 (Personnel Advisor) | 13.35                                                    |
| GS-4/5 (Clerical)           | 6.51                                                     |
|                             | $\$68.24 + 12.5\% \text{ fringes} = \underline{\$76.77}$ |

Costs:

$$(8900 + 678 + 200) \times \$76.77 \times 1/2 = \$375,329$$

## II. Section 403: Cost of Promotions

Assumptions:

- o 875 LP/LVN's (about 15% of total of 5850 GS-5 positions) will be advanced from GS-5 to GS-6 at average cost of \$1,239 each (GS-5/5 to GS-6/4).
- o 90 PT's (about 20% of total of 450 GS-9 positions) will be advanced from GS-9 to GS-11 at average cost of \$1,552 each (GS-9/5 to GS-11/1).
- o 200 RT's will be promoted from GS-7 to GS-9 at average cost of \$1,489 each (GS-7/5 to GS-9/1).

Costs:

|               |   |                   |
|---------------|---|-------------------|
| 875 X \$1,239 | = | \$1,084,125       |
| 90 X \$1,552  | = | \$ 139,680        |
| 200 X \$1,489 | = | <u>\$ 297,800</u> |

$$\text{TOTAL} = \$1,521,605 + 12.5\% \text{ Fringes} = \underline{\$1,711,806}$$

## III. Section 403: Cost of Step Advancements

Assumptions:

- o 1,000 LP/LVN's at average grade of GS-5 receive average of two step advancement each at \$446 per step.
- o 225 PT's at average grade of GS-9 receive average of two step advancement each at \$675 per step.
- o No step advancements are made for RT's. All 200 RT's converted to Title 38 system will have been advanced to full grade (GS-9 equivalent) on nurse pay schedule. This cost was included in paragraph II above.

Costs:

$$1,000 \times \$446 \times 2 = \$892,000$$

$$225 \times \$675 \times 2 = \$303,750$$

$$\text{TOTAL} = \$1,195,750 + 12.5\% \text{ fringes} = \underline{\$1,345,219}$$

## IV. Section 404: Cost of Additional Night Shift Differential

Assumptions:

- o There are no shift differential costs for PT's.
- o 50% of all 200 RT's converted to Title 38 work on evening or night shifts.
- o 60% of 8,900 LP/LVN's work evening or night shifts.
- o Under Title 5, employees generally receive 6 hours shift differential for each 8 hours worked. Under Title 38, employees are paid 8 hours differential for each shift. Thus, 25% more hours are subject to shift differential under Title 38.
- o Average salary of all LP/LVN's is \$14,707 (GS-5/4) or \$7.05 per hour. Thus, 10% differential is \$.70 per hour.
- o Average salary of all RT's is \$20,256 (GS-9/1) or \$9.70 per hour. Thus, 10% differential is \$.97 per hour.

Costs:

- o 8,900 LP/LVN's X 2,080 hours per year X .6 coverage X .25 additional hours X \$.70 = \$1,943,760
- o 200 RT's X 2,080 X .5 coverage X .25 X \$.97 = \$50,440
- o Total Cost = \$1,943,760 + \$50,440 = \$1,994,200

## V. Section 404: Cost of Saturday Premium Pay

Assumptions:

- o No Saturday premium costs for PT's or RT's.
- o 10% of 8,900 LP/LVN's will eventually receive Saturday pay. 5% will be approved in year 1. Additional 5% will be approved in year 2. This total will remain constant in years 3, 4 and 5.
- o Saturday premium is 25% of hourly rate. Average hourly rate for LP/LVN's is \$7.05 (GS-5/4).

Costs:

- o Year 1:

$$8,900 \times .05 \times \$7.05 \times .25 \times 8 \text{ hours} \times 52 \text{ Saturdays per year} = \underline{\$326,274}$$

- o Years 2 thru 5:

$$\$326,274 \times 4 = \underline{\$1,305,096}$$

## VI. Section 404: Cost of "On Call" Pay

Assumptions:

- o No net incremental costs are attributed to S.11 for "On Call" pay. The bill would generate a small increased cost due to a small number of LP/LVN's and RT's receiving "On Call" pay at 10% of their hourly rate and overtime pay. However, this cost would be offset by reduced costs for standby premium pay under 5 U.S.C. 5545.

## VII. Section 404: Cost of Above Minimum Entrance Rates and Special Salary Rate Ranges

Assumptions:

- o No incremental costs are attributed to S.11 for above minimum entrance rates and special salary rate ranges. These pay flexibilities already exist for LP/LVN's, PT's and RT's under Title 5 pursuant to P.L. 96-330, Section 112, now codified at 38 U.S.C. 4107(g)(1)(b). It is also assumed that requests for special rates would decrease under S.11 because of the availability of other pay fixing flexibilities, such as the ability to make new appointments of highly qualified employees above the minimum step for a grade.



## VIII. Section 405: Cost of Conversion to Title 38 Leave System

Assumptions:

- o 8,900 LP/LVN's, 678 PT's and 200 RT's would be converted to the same leave system now in effect for nurses, i.e., all earn 26 days annual leave per year regardless of years of service.
- o About one third of employees are now in Leave Group I, earning 13 days leave per year. These employees would earn an additional 13 days under Title 38.
- o About one third of employees are now in Leave Group II, earning 20 days leave per year. These employees would earn an additional 6 days under Title 38.
- o About one third of employees are now in Leave Group III, earning 26 days per year. These employees would earn no additional leave under Title 38.
- o Average Salaries in Leave Group I are:
  - LP/LVN's - GS-5/1, \$13,369
  - PT's - GS-9/1, \$20,256
  - RT's - GS-9/1, \$20,256
- o Average Salaries in Leave Group II are:
  - LP/LVN's - GS-5/8, \$16,491
  - PT's - GS-9/6, \$23,631
  - RT's - GS-9/5, \$22,956

Costs:

- o Costs for Employees now in Leave Group I:
  - \$6.40 per hour X 8 X 13 X 3000 LP/LVN's = \$1,996,800
  - \$9.70 per hour X 8 X 13 X 226 PT's = \$227,989
  - \$9.70 per hour X 8 X 13 X 67 RT's = \$67,590
  - TOTAL = \$1,996,800 + \$227,989 + \$67,590 = \$2,292,379
- o Costs for Employees in Leave Group II:
  - \$7.90 per hour X 8 X 6 X 3000 LP/LVN's = \$1,137,600
  - \$11.32 per hour X 8 X 6 X 226 PT's = \$122,799
  - \$11.00 per hour X 8 X 6 X 67 RT's = \$35,376
  - TOTAL = \$1,137,600 + \$122,799 + \$35,376 = \$1,295,775
- o GRAND TOTAL = \$2,292,379 + \$1,295,775 = \$3,588,154

## IX. Five Year Cost Projection for Title IV of S.11

|                                         | <u>YEAR 1</u>    | <u>YEAR 2</u>    | <u>YEAR 3</u>    | <u>YEAR 4</u>    | <u>YEAR 5</u>    |
|-----------------------------------------|------------------|------------------|------------------|------------------|------------------|
| Initial<br>Conversion,<br>Board Actions | \$375,329        | 0                | 0                | 0                | 0                |
| Promotions                              | 1,711,806        | \$1,711,806      | \$1,711,806      | \$1,711,806      | \$1,711,806      |
| Step<br>Advancements                    | 1,345,219        | 1,345,219        | 1,345,219        | 1,345,219        | 1,345,219        |
| Night Shift<br>Differential             | 1,994,200        | 1,994,200        | 1,994,200        | 1,994,200        | 1,994,200        |
| Saturday<br>Premium Pay                 | 326,274          | 652,548          | 652,548          | 652,548          | 652,548          |
| Annual Leave                            | <u>3,588,154</u> | <u>3,588,154</u> | <u>3,588,154</u> | <u>3,588,154</u> | <u>3,588,154</u> |
| TOTAL                                   | \$9,340,982      | \$9,291,927      | \$9,291,927      | \$9,291,927      | \$9,291,927      |

TOTAL 5 YEAR COST \$46,508,690



United States  
Office of  
Personnel Management

Washington, D.C. 20415

In Reply Refer To

Your Reference

MAY 16 1983

Honorable Alan K. Simpson  
Chairman  
Committee on Veterans' Affairs  
United States Senate  
Washington, D.C. 20510

Dear Mr. Chairman:

This is to advise you of the views of the Office of Personnel Management on title IV of S. 11, the "Veterans' Programs Improvement Act of 1983." It is our understanding that the provisions of this title have been incorporated into the Committee's amendments to S. 578, and we wish to advise the Committee of our objections to these provisions.

Title IV of S. 11 would authorize conversion of some 9,000 practical and vocational nurses and physical and respiratory therapists from the competitive service and the General Schedule pay system to the title 38 personnel system.

As OPM testified on March 9, 1983, the considerable cost of such conversions are unwarranted by the circumstances. While VA has had some difficulty in recruiting and retaining personnel in certain shortage occupations, we do not think this is sufficient justification for these conversions. There are other alternatives.

The title 38 personnel system bases pay primarily on employee qualifications, while the title 5 system bases pay on differences in the difficulty and responsibility of the work actually being performed. The title 5 approach results in a process where salary costs can be better controlled than under title 38. For example, approximately 75 percent of all physicians under the General Schedule are in GS-14 and below, while 83 percent of VA's title 38 physicians are paid at rates above those for GS-14. The same sort of escalated grade and pay structure might well occur for any other occupation converted to title 38.

Our major concern with the proposed conversions, however, is that the higher pay and benefits under title 38 would be given only to those respiratory therapists who hold credentials. This would be without regard for differences in actual duties and responsibilities. Yet occupational studies conducted for respiratory therapists show that, in most instances, there are no differences between work performed by credentialed and noncredentialed employees. It is not uncommon to find that the assignments,

educational attainment, and performance of both groups are equal. Consequently, we foresee inequities and an adverse effect on the retention and morale of VA employees who would not be covered under title 38 because they do not hold a credential.

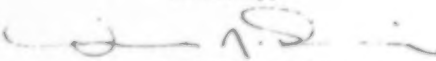
In regard to recruiting difficulties for practical and vocational nurses, the largest group at issue, we believe OPM has done a good job in recruiting candidates under the competitive examining system. Furthermore, we are developing a nationwide automated rating system for these positions, which will make it possible to score a large number of applications quickly and economically. This will enhance the level of service provided to the VA.

Current law permits the establishment of special salary rates for these occupations in order to meet recruitment needs or provide competitive pay rates in one or more areas or locations. Special rates have been established for licensed practical and vocational nurses in 20 locations in seven OPM regions. For therapists, very few problems have been indicated. Special salary rates have been issued for physical therapists in nine locations and for respiratory technicians in only five locations. We are confident that this existing authority provides sufficient pay flexibility to ensure that staffing needs for these occupations will continue to be met in the future.

All in all, conversion of these positions to the title 38 personnel system is unnecessary and the cost resulting from the conversion is unwarranted.

The Office of Management and Budget advises that from the standpoint of the Administration's program there is no objection to the submission of this report.

Sincerely,



Donald J. Devine  
Director



## CHANGES IN EXISTING LAW MADE BY S. 578 AS REPORTED

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, existing law in which no change is proposed is shown in roman):

## TITLE 38—UNITED STATES CODE

\* \* \* \* \*

## PART I—GENERAL PROVISIONS

\* \* \* \* \*

## CHAPTER 1—GENERAL

\* \* \* \* \*

## § 111. Travel expenses

(a) \* \* \*

\* \* \* \* \*

(e)(1) \* \* \*

\* \* \* \* \*

(4) Before determining rates under this section and not later than sixty days after any alteration in the rates described in paragraph (3)(C) of this subsection, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing the rates the Administrator proposes to establish or continue with a full justification therefor in terms of each of the limitations and factors set forth in this section.

(5)(A) *In order to achieve compliance with the limitation in subsection (b) of section 301 of the Veterans' Health Care and Programs Improvement Act of 1983 on certain obligations under this section in fiscal year 1984, the Administrator is hereby authorized to and shall prescribe regulations to be effective on October 1, 1983, restricting, to the extent necessary to achieve such compliance, the making of payments under this section to persons other than persons receiving benefits under this title for or in connection with a service-connected disability.*

(B) *The substantive provisions so restricting such payments may be continued in effect in regulations after the end of such fiscal year.*

\* \* \* \* \*

## CHAPTER 3—VETERANS' ADMINISTRATION; OFFICERS AND EMPLOYEES

## SUBCHAPTER 1—VETERANS' ADMINISTRATION

Sec.

201. Veterans' Administration an independent agency.

202. Seal of the Veterans' Administration.  
203. Availability of appropriations.

#### SUBCHAPTER II—ADMINISTRATOR OF VETERANS' AFFAIRS

210. Appointment and general authority of Administrator; Deputy Administrator.  
211. Decisions by Administrator; opinion of Attorney General.  
212. Delegation of authority and assignment of duties.  
213. Contracts and personal services.  
214. Report to the Congress.  
215. Publication of laws relating to veterans.  
217. Studies of rehabilitation of disabled persons.  
218. Standards of conduct and arrests for crimes at hospitals, domiciliaries, cemeteries, and other Veterans' Administration reservations.  
219. Evaluation and data collection.  
220. Coordination and promotion of other Federal programs affecting veterans and their dependents.  
221. Advisory Committee on Former Prisoners of War.  
222. Advisory Committee on Women Veterans.

### Subchapter I—Veterans' Administration

#### § 203. Availability of appropriations

(a) Any funds appropriated to the Veterans' Administration may, to the extent provided in this title or an appropriations Act, remain available until expended.

(b) An appropriation may be used for a settlement of more than \$1,000,000 on a construction contract only if the settlement is audited independently for reasonableness and appropriateness of expenditures and the settlement is [not] provided for specifically in an appropriation law.

### Subchapter II—Administrator of Veterans' Affairs

#### § 221. Advisory Committee on Former Prisoners of War

#### § 222. Advisory Committee on Women Veterans

(a)(1) *The Administrator shall establish an advisory committee to be known as the Advisory Committee on Women Veterans (hereinafter in this section referred to as "the Committee").*

(2) *The members of the Committee shall be appointed by the Administrator from the general public and shall include—*

(A) *appropriate representatives of women veterans;*

(B) *individuals who are recognized authorities in fields pertinent to the needs of women veterans, including the gender-specific health-care needs of women; and*

(C) *appropriate representatives of both female and male service-connected-disabled veterans, including at least one female service-connected disabled veteran and at least one male service-connected disabled veteran.*

*The Committee shall also include, as ex officio members, the Chief Medical Director and the Chief Benefits Director, or their designees, and one public member and one military member of the Department of Defense Advisory Committee on Women in the Services selected therefrom by the Administrator after consultation with the Secretary of Defense. The Administrator may also invite representatives of such other departments and agencies of the United States as the Administrator considers appropriate to participate in the meetings and other activities of the Committee.*

*(3) The Administrator shall determine the number, terms of service, and pay and allowances of members of the Committee appointed by the Administrator, except that a term of service of any such member may not exceed 3 years. The Administrator may reappoint any such member of such additional terms of service as the Administrator considers appropriate.*

*(4) The Committee shall meet not less than three times in fiscal year 1984 and thereafter at such times as determined by the Committee but not less than two times in each fiscal year.*

*(b) The Administrator shall, on a regular basis, consult with and seek the advice of the Committee with respect (1) to the administration of benefits under this title for women veterans, (2) reports and studies pertaining to women veterans, (3) and the needs of such veterans with respect to compensation, health care, rehabilitation, outreach, and other benefits and programs administered by the Veterans' Administration.*

*(c) Not later than July 1, 1984, and not later than July 1 of each year thereafter, the Committee shall submit to the Administrator a report on the programs and activities of the Veterans' Administration that pertain to women veterans. Each such report shall contain (1) an assessment of the needs of such veterans with respect to compensation, health care, rehabilitation, outreach, and other benefits and programs administered by the Veterans' Administration, (2) a review of the programs and activities of the Veterans' Administration designed to meet such needs, and (3) such recommendations (including recommendations for administrative and legislative action) as the Committee considers appropriate. Within 30 days after receiving each such report, the Administrator shall submit it to the Congress with any comments concerning the report that the Administrator considers appropriate. The Committee may also submit to the Administrator such other reports and recommendations as the Committee considers appropriate. The Administrator shall submit with each annual report submitted to the Congress pursuant to section 214 of this title a summary of all reports and recommendations of the Committee submitted to the Administrator since the previous annual report of the Administrator submitted to the Congress pursuant to such section.*

\* \* \* \* \*

## **PART II—GENERAL BENEFITS**

\* \* \* \* \*

## CHAPTER II—COMPENSATION FOR SERVICE-CONNECTED DISABILITY OR DEATH

\* \* \* \* \*

### Subchapter II—Wartime Disability Compensation

\* \* \* \* \*

#### § 312. Presumptions relating to certain diseases and disabilities

(a) \* \* \*

\* \* \* \* \*

(b) For the purpose of section 310 of this title and subject to the provisions of section 313 of this title, in the case of a veteran who is a former prisoner of war and who was detained or interned for not less than thirty days, the disease of—

- (1) avitaminosis,
- (2) beriberi (including beriberi heart disease),
- (3) chronic dysentery,
- (4) helminthiasis,
- (5) malnutrition (including optic atrophy associated with malnutrition),
- (6) pellagra,
- (7) any other nutritional deficiency,
- (8) psychosis, [or]
- (9) any of the anxiety states, or
- (10) *dysthymic disorder (or depressive neurosis)*,

which became manifest to a degree of 10 per centum or more after active military, naval, or air service shall be considered to have been incurred in or aggravated by such service, notwithstanding that there is no record of such disease during the period of service.

\* \* \* \* \*

### Subchapter VI—General Compensation Provisions

\* \* \* \* \*

#### § 360. Special consideration for certain cases of blindness or bilateral kidney involvement or bilateral deafness

Where any veteran (1) has suffered [(1)] blindness in one eye as a result of service-connected disability and has suffered blindness in the other eye as a result of non-service-connected disability not the result of such veteran's own willful misconduct, or (2) has suffered the loss or loss of use of one kidney as a result of service-connected disability, and has suffered severe involvement of the other kidney such as to cause total disability, as a result of non-service-connected disability not the result of such veteran's own willful misconduct, or (3) has suffered total deafness in one ear as a result of service-connected disability and has suffered total deafness in the other ear as the result of non-service-connected disability not the result of such veteran's own willful misconduct, the Administrator shall assign and pay to the veteran concerned the applicable rate of compensation under this chapter as if such veter-



an's blindness in both eyes or such bilateral kidney involvement or such total deafness in both ears were the result of service-connected disability.

### § 361. Payment of disability compensation in disability severance cases

The deduction of disability severance pay from disability compensation, as required by section 1212(c) of title 10, [United States Code,] shall be made at a monthly rate not in excess of the rate of compensation to which the former member would be entitled based on the degree of such former member's disability as determined on the initial Veterans' Administration rating.

\* \* \* \* \*

## CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

### SUBCHAPTER I—GENERAL

Sec.

601. Definitions.

602. Presumption relating to psychosis.

### SUBCHAPTER II—HOSPITAL, NURSING HOME OR DOMICILIARY CARE AND MEDICAL TREATMENT

610. Eligibility for hospital, nursing home and domiciliary care.

611. Care during examinations and in emergencies.

612. Eligibility for medical treatment.

612A. Eligibility for readjustment counseling and related mental health services.

613. Medical care for survivors and dependents of certain veterans.

614. Fitting and training in use of prosthetic appliances; seeing-eye dogs.

615. Tobacco for hospitalized veterans.

616. Hospital care by other agencies of the United States.

617. Invalid lifts and other devices.

618. Therapeutic and rehabilitative activities.

619. Repair or replacement of certain prosthetic and other appliances.

620. Transfers for nursing home care; *adult day health care pilot program*.

620A. Treatment and rehabilitation for alcohol or drug dependence or abuse disabilities; pilot program.

### SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

621. Power to make rules and regulations.

622. Evidence of inability to defray necessary expenses.

623. Furnishing of clothing.

624. Hospital care, medical services, and nursing home care abroad.

626. Reimbursement for loss of personal effects by natural disaster.

627. Persons eligible under prior law.

628. Reimbursement of certain medical expenses.

629. Recovery by the United States of the cost of certain care and services.

630. Chiropractic services.

630A. Transfers for community residential care.

\* \* \* \* \*

### Subchapter I—General

#### § 601. Definitions

For the purposes of this chapter—

(1) The term "disability" means a disease, injury, or other physical or mental defect.

(2) The term "veteran of any war" includes any veteran of the Indian Wars, or any veteran awarded the Medal of Honor.

(3) The term "period of war" includes each of the Indian Wars.

(4) The term "Veterans' Administration facilities" means—

(A) facilities over which the Administrator has direct jurisdiction;

(B) Government facilities for which the Administrator contracts; and

(C) private facilities for which the Administrator contracts when facilities described in clause (A) or (B) of this paragraph are not capable of furnishing economical care because of geographical inaccessibility or of furnishing the care or services required in order to provide (i) hospital care or medical services to a veteran for the treatment of a service-connected disability or a disability for which a veteran was discharged or released from the active military, naval, or air service; (ii) medical services for the treatment of any disability of a veteran described in clause (1)(B) or (2) of the first sentence, or in the third sentence, of section 612(f) of this title or of a veteran described in section 612(g) of this title if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in facilities described in clauses (A) and (B) of this paragraph; (iii) hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving medical services in a facility described in clause (A) or (B) of this paragraph until such time as the veteran can be safely transferred to any such facility; (iv) hospital care for women veterans, and, until September 30, 1983, medical services described in section 612(f)(1)(A) of this title for a woman veteran if the Administrator has determined, based on an examination by a physician employed by the Veterans' Administration (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that a disability of such woman veteran relating to her gender precludes appropriate treatment in facilities described in clause (A) or (B) of this paragraph; (v) hospital care, or medical services that will obviate the need for hospital admission, for veterans in a State not contiguous to the forty-eight contiguous States, except that the annually determined hospital patient load and incidence of the provision of medical services to veterans hospitalized or treated at the expense of the Veterans' Administration in Government and private facilities in each such noncontiguous State shall be consistent with the patient load or incidence of the provision of medical services for veterans hospitalized or treated by the Veterans' Administration within the forty-eight contiguous States, but the authority of the Administrator under this subclause (except with respect to Alaska and Hawaii) shall expire on September 30, [1983] 1984, and until such date the Administrator may, if necessary to prevent hardship, waive the applicability to the

Commonwealth of Puerto Rico and to the Virgin Islands of the restrictions in this subclause with respect to hospital patient loads and incidence of provision of medical services; or (vi) diagnostic services necessary for determination of eligibility for, or of the appropriate course of treatment in connection with, the provision of medical services at independent Veterans' Administration outpatient clinics to obviate the need for hospital admission.

In the case of any veteran for whom the Administrator contracts to provide treatment in a private facility pursuant to the provisions of this paragraph, the Administrator shall periodically review the necessity for continuing such contractual arrangement pursuant to such provision.

\* \* \* \* \*

(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services—

(A)(i) surgical services, dental services and appliances as described in sections 610 and 612 of this title, optometric and podiatric services (*in the case of a person otherwise receiving care or services under this chapter*), preventive health-care services as defined in section 662 of this title, and (except under the conditions described in section 612(f)(1)(A) of this title), wheelchairs, artificial limbs, trusses and similar appliances, special clothing made necessary by the wearing of prosthetic appliances, and such other supplies or services as the Administrator determines to be reasonable and necessary, and (ii) travel and incidental expenses pursuant to the provisions of section 111 of this title; and

(B) such consultation, professional counseling, training, and mental health services as are necessary in connection with the treatment—

(i) of the service-connected disability of a veteran pursuant to section 612(a) of this title, and

(ii) in the discretion of the Administrator, of the non-service-connected disability of a veteran eligible for treatment under section 612(f)(1)(B) of this title where such services were initiated during the veteran's hospitalization and the provision of such services on an outpatient basis is essential to permit the discharge of the veteran from the hospital.

for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, as may be essential to the effective treatment and rehabilitation of the veteran (including, under the terms and conditions set forth in section 111 of this title, travel and incidental expenses of such family member or individual in the case of a veteran who is receiving care for a service-connected disability, or in the case of dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title). For the purposes of this paragraph, a dependent or survivor of a veteran receiving care under the last sentence of section 613(b) of this title shall be eligible for the same medical services as a veteran.

(7) The term "domiciliary care" includes necessary medical services and travel and incidental expenses pursuant to the provisions of section 111 of this title.

(8) The term "rehabilitative services" means such professional counseling, and guidances services and treatment programs (other than those types of vocational rehabilitation services provided under chapter 31 of this title) as are necessary to restore, to the maximum extent possible, the physical, mental, and psychological functioning of an ill or disabled person.

(9) *The term "chiropractic services" means the manual manipulation of the spine performed by a chiropractor (who is licensed as such by the State in which he or she performs such services and who meets the uniform minimum standards promulgated for chiropractors under section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))) to correct a subluxation of the spine. For the purposes of this paragraph, such term does not include physical examinations, laboratory tests, radiologic services, or other tests or services determined by the Administrator to be excluded.*

\* \* \* \* \*

## Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical Treatment

### § 610. Eligibility for hospital nursing home and domiciliary care

(a) The Administrator, within the limits of Veterans' Administration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to—

(1)(A) any veteran for a service-connected disability; or (B) any veteran for a non-service-connected disability if such veteran is unable to defray the expenses of necessary hospital or nursing home care;

(2) a veteran whose discharge or release from the active military, naval, or air service was for a disability incurred or aggravated in line of duty;

(3)(A) a person who is in receipt of, or but for the receipt of retirement pay would be entitled to, disability compensation; or (B) a person who, but for a suspension pursuant to section 351 of this title (or both such a suspension and the receipt of retired pay), would be entitled to disability compensation, but only to the extent that such person's continuing eligibility for such care is provided for in the judgment or settlement described in such section;

(4) a veteran who is a former prisoner of war;

(5) a veteran who meets the conditions of subsection (e) of this section; and

(6) any veteran for a non-service-connected disability if such veteran is sixty-five years of age or older.

\* \* \* \* \*

### § 612A. Eligibility for readjustment counseling and related mental health services

(a) Upon the request of any veteran who served on active duty during the Vietnam era, the Administrator shall, within the limits



of Veterans' Administration facilities, furnish counseling to such veteran to assist such veteran in readjusting to civilian life if such veteran requests such counseling within two years after the date of such veteran's discharge or release from active duty or by September 30, [1984] 1985, whichever is later. Such counseling shall include a general mental and psychological assessment to ascertain whether such veteran has mental or psychological problems associated with readjustment to civilian life.

\* \* \* \* \*

(g)(1) During the twelve-month period ending on September 30, [1984] 1985, the Administrator shall take appropriate steps to ensure—

(A) the orderly transition, by October 1, [1984] 1985, of that part of the program established under this section for the provision of readjustment counseling services by Veterans' Administration personnel from a program providing such services primarily through centers located in facilities situated apart from the health-care facilities operated by the Veterans' Administration for the provision of other health-care services under other provisions of this chapter to a program providing readjustment counseling services primarily through such health-care facilities; and

(B) the continued availability after such date of readjustment counseling and related mental health services under this section to veterans eligible for the provision of such counseling and services who requested such counseling before such date.

(2) Not later than [April 1] September 30, 1984, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report [on] *containing (A) a description of the plans made and actions taken to carry out this subsection, and (B) the Administrator's evaluation of the effectiveness of the readjustment counseling services provided pursuant to this section in helping to meet the readjustment needs of veterans who served on active duty during the Vietnam era, with particular reference to identification and treatment of post-traumatic stress disorder.*

\* \* \* \* \*

#### § 620. Transfers for nursing home care; adult day health care pilot program

(a) Subject to subsection (b) and except as provided in subsection (e) of this section, the Administrator may transfer—

(1) any veteran who has been furnished care by the Administrator in a hospital under the direct jurisdiction of the Administrator, and

(2) any person (A) who has been furnished care in any hospital of any of the Armed Forces, (B) who the appropriate Secretary concerned has determined has received maximum hospital benefit but requires a protracted period of nursing home care, and (C) who upon discharge therefrom will become a veteran, to any public or private institution not under the *direct* jurisdiction of the Administrator which furnishes nursing home care, for care

at the expense of the United States, only if the Administrator determines that—

(i) such veteran has received maximum benefits from such care in such hospital, but will require a protracted period of nursing home care which can be furnished in such institution, and

(ii) the cost of such nursing home care in such institution will not exceed 45 percent of the cost of care furnished by the Veterans' Administration in a general hospital under the direct and exclusive jurisdiction of the Administrator, as such cost may be determined annually by the Administrator, or not to exceed 50 percent of such cost where determined necessary by the Administrator, upon recommendation of the Chief Medical Director, to provide adequate care.

Nursing home care may not be furnished pursuant to this section at the expense of the United States for more than six months in the aggregate in connection with any one transfer, except (I) in the case of the veteran whose hospitalization was primarily for a service-connected disability, or (II) where in the judgment of the Administrator a longer period is warranted in the case of any other veteran. Any veteran who is furnished care by the Administrator in a hospital in Alaska or Hawaii may be furnished nursing home care under the provisions of this section even if such hospital is not under the direct jurisdiction of the Administrator.

(b) No veteran may be transferred or admitted to any institution for nursing home care or *adult day health care* under this section, unless such institution is determined by the Administrator to meet such standards as the Administrator may prescribe. The standards prescribed and any report of inspection of institutions furnishing care to veterans under this section made by or for the Administrator shall, to the extent possible, be made available to all Federal, State, and local agencies charged with the responsibility of licensing or otherwise regulating or inspecting such institutions.

\* \* \* \* \*

(e)(1)(A) *Subject to subparagraphs (B) and (C) of this paragraph, the Administrator may conduct a pilot program of adult day health care under which the Administrator, in the case of a veteran described in paragraph (1) of subsection (a) of this section who is eligible for transfer pursuant to such subsection, may transfer such veteran for the purpose of such veteran being furnished such care, at the expense of the United States, to any public or private facility not under the direct jurisdiction of the Administrator which furnishes such care. Such care may not be furnished under this paragraph at the expense of the United States for more than 6 months in the aggregate in connection with any one transfer, except (i) in the case of a veteran whose hospitalization was primarily for a service-connected disability, or (ii) where in the judgment of the Administrator a longer period is warranted in the case of any other veteran.*

(B)(i) *The terms and conditions set forth in subsections (b) and (c) of this section applicable (I) to the transfer or admission of veterans to institutions for nursing home care under this section, and (II) to contracts for the provision of such care, respectively, shall apply to the furnishing of adult day health care under this subsection.*

(ii) The authorities provided in the final sentence of subsection (a) of this section and in the first two sentences of subsection (d) of this section with respect to furnishing nursing home care to certain veterans shall be available to the Administrator for the furnishing of adult day health care to such veterans under this subsection.

(C) Adult day health care may be furnished to a veteran under this subsection only if the Administrator determines that the cost per week of such care will be less than the lesser of the cost per week of furnishing such veteran nursing home care under this section or the cost per week of furnishing such veteran nursing home care in a facility under the direct jurisdiction of the Administrator.

(2) In exchange for the United States being relieved from paying all or part of the expenses that would otherwise be paid by the United States under paragraph (1) of this subsection to a facility providing care to an eligible veteran under such paragraph, the Administrator may, pursuant to a contractual arrangement with such facility, provide such facility with inkind assistance through Veterans' Administration employees and the sharing of other Veterans' Administration resources. In any such contractual arrangement, the Administrator may agree to provide such assistance for utilization solely in the furnishing of adult day health care and only to the extent that the cost of such assistance is equal to or less than the amount of the expenses that, under such arrangement, the United States will be relieved from paying.

(3) The Administrator may, as part of the pilot program under paragraph (1) of this subsection, establish and conduct at each of four geographically dispersed hospital or outpatient facilities over which the Administrator has direct jurisdiction a program of adult day health care for veterans who are eligible for such care under paragraph (1) of this subsection.

(4) To the extent that the pilot program authorized by this subsection is carried out, the Administrator—

(A) shall plan and conduct such program and a study thereof so as to provide for the assessment and demonstration of (i) any medical efficacy and cost-effectiveness of furnishing adult day health care as an alternative for nursing home care, and (ii) the comparative advantages and disadvantages of providing such care through facilities not under the direct jurisdiction of the Administrator and facilities that are under such jurisdiction; and

(B) may not furnish adult day health care under this subsection after September 30, 1987.

(5) In the annual reports to the Congress for each of fiscal years 1984, 1985, and 1986 as required by section 214 of this title, the Administrator shall include detailed descriptions of the activities carried out under this subsection. Not later than December 1, 1986, the Administrator shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report containing—

(A) the results of any study conducted under paragraph (4)(A) of this subsection; and

(B) any recommendations for legislative and administrative action that the Administrator considers appropriate.

[(e)](f)(1) For the purposes of this section, the term "nursing home care" includes intermediate care as determined by the Administrator in accordance with regulations which the Administrator shall prescribe. The cost of intermediate care for purposes of payment by the United States pursuant to subsection (a)(ii) of this section shall be determined by the Administrator except that the rate of reimbursement shall be commensurately less than that provided for nursing home care (as defined in section 101(28) of this title).

(2) For the purposes of this section, the term "adult day health care" means health and social services furnished to individuals in congregate settings during daytime hours for the purpose of enabling such individuals to reside in supportive home environments rather than in nursing home care facilities. Such health and social services may include medical services furnished on an outpatient or ambulatory basis, midday meals, and transportation, including transportation between home and the facility providing such health and social services.

\* \* \* \* \*

### Subchapter III—Miscellaneous Provisions Relating to Hospital and Nursing Home Care and Medical Treatment of Veterans

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#### § 629. Recovery by the United States of the cost of certain care and services

\* \* \* \* \*

#### § 630. Chiropractic services

(a) The Administrator shall, under regulations which the Administrator shall prescribe, reimburse a veteran eligible for medical services under this chapter for the reasonable charge for chiropractic services for which such veteran has made payment, or, in lieu of such reimbursement make payment of the reasonable charge for such chiropractic services directly to the chiropractor who furnished such services, if—

(1) such chiropractic services were for the treatment of a service-connected neuromusculoskeletal condition of the spine,

(2) the veteran is a veteran who has been furnished hospital care by the Veterans' Administration for a neuromusculoskeletal condition of the spine within a 12-month period prior to the provision of such chiropractic services, or

(3) the veteran is a veteran described in section 612(f)(2) of this title who has been furnished hospital care or medical services by the Veterans' Administration for a neuromusculoskeletal condition of the spine, to the extent that such veteran is not entitled to such chiropractic services or reimbursement for the expenses of such services under an insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar arrangement for the purpose of providing, paying for, or reimbursing expenses for such services.



(b)(1) The Administrator shall, in consultation with appropriate public and nonprofit private organizations and other Federal departments and agencies that provide reimbursement for chiropractic services, establish a schedule of reasonable charges for such services, which schedule shall be consistent with the reasonable charges allowed under title XVIII of the Social Security Act (42 U.S.C. ch. 7).

(2) The amount payable by the Administrator for chiropractic services furnished under this section shall not exceed \$400 in any 12-month period in the case of any veteran.

(c) Notwithstanding any other provision of this title, total expenditures for chiropractic services reimbursed under this section shall not exceed \$2,000,000 in any fiscal year and no reimbursement or payment may be made under this section for chiropractic services furnished after September 30, 1987.

#### **§ 630A. Transfers for community residential care**

(a) Subject to the terms and conditions set forth in this section and regulations prescribed by the Administrator under this section, the Administrator may assist a veteran to whom the Administrator is furnishing hospital, domiciliary, or nursing home care or medical services on an outpatient basis or has furnished such care or services within the preceding 12 months and for whom placement in a community residential-care facility is appropriate by referring such veteran for and aiding such veteran in obtaining placement in such a facility.

(b)(1) The Administrator may not provide assistance under subsection (a) of this section with respect to a community residential-care facility unless the Administrator has approved such facility in accordance with paragraph (2) of this subsection.

(2) The Administrator's approval of such a facility under paragraph (1) of this subsection shall be based upon the Administrator's determination, after inspection of such facility, that such facility meets the standards set forth in the regulations prescribed under this section. Such standards shall include:

(A) health and safety criteria, including a requirement of compliance with applicable State laws and local ordinances relating to health and safety;

(B) a requirement that the costs charged for care by a community residential-care facility be reasonable, as determined by the Administrator, giving consideration to such factors as (i) the level of care, supervision, and other services to be provided, (ii) the cost of goods and services in the geographical area in which the facility is located, and (iii) comparability with other facilities in such area providing similar services;

(C) criteria for determining the resources that a community residential-care facility needs in order to provide an appropriate level of services to veterans; and

(D) such other criteria as the Administrator determines are appropriate to protect the welfare of veterans placed in community residential-care facilities under this section.

(3) Payment of the charges for any care or services provided to a veteran whom the Administrator has referred to a community residential-care facility under this section shall not be the responsibility of the United States Government or the Veterans' Administration.

(c)(1) *The Administrator shall provide for periodic inspection of community residential-care facilities to determine continued compliance with the standards set forth in regulations prescribed under this section. Such standards and any report of inspection of such facilities under subsection (b)(2) of this section or under this subsection made by or for the Administrator shall, to the extent possible, be made available to all Federal, State, and local agencies charged with the responsibility of licensing or otherwise regulating or inspecting such facilities.*

(2) *If the Administrator determines that such a facility is not in compliance with such standards, the Administrator, in accordance with regulations prescribed under this section—*

*(A) shall cease to refer veterans to such facility; and*

*(B) may, with the permission of the veteran or the person or entity authorized by law to give permission on behalf of the veteran, assist in removing a veteran from such facility.*

*Regulations prescribed to carry out this paragraph shall provide for reasonable notice and, upon request made on behalf of such facility, a hearing before any action authorized by this paragraph is taken.*

*(d) The Administrator shall prescribe regulations to carry out this section.*

*(e) For the purpose of this section, the term "community residential-care facility" means a residential facility that provides, at a minimum, room and board and such limited personal care for and supervision of residents as the Administrator determines, in accordance with regulations prescribed under this section, are necessary for such resident's health, safety, and welfare.*

\* \* \* \* \*

#### Subchapter V—Payments to State Homes

##### § 641. Criteria for payment

(a) The Administrator shall pay each State at the per diem rate of—

- (1) ~~[\$6.35]~~ \$7.30 for domiciliary care,
- (2) ~~[\$12.10]~~ \$13.95 for nursing home care, and
- (3) ~~[\$13.25]~~ \$15.25 for hospital care,

for each veteran receiving such care in a State home, if such veteran is eligible for such care in a Veterans' Administration facility.

(b) In no case shall the payments made with respect to any veteran under this section exceed one-half of the cost of the veteran's care in such State home.

\* \* \* \* \*

#### Subchapter VII—Preventive Health-Care Services Pilot Program

##### § 661. Purpose

The purpose of this subchapter is to provide for a preventive health-care services pilot program [under which the Administrator may attempt to] in order to help (1) insure the best possible health care for certain veterans otherwise being furnished care or services

*under this chapter, including veterans with service-connected disabilities rated at 50 per centum or more and [for certain] veterans being furnished [treatment] care or services involving a service-connected disability under this chapter, by furnishing to such veterans feasible and appropriate preventive health-care services, and (2) determine the cost-effectiveness and medical advantages of furnishing such preventive health-care services.*

\* \* \* \* \*

#### **§ 663. Preventive health-care services**

(a)(1) In order to carry out the purpose of this subchapter, the Administrator, within the limits of Veterans' Administration facilities and in accordance with regulations which the Administrator shall prescribe, [may] *shall, during fiscal years 1984 through 1988, furnish to any veteran described in section 612(f)(2) of this title otherwise being furnished care or services under this chapter, and to any veteran receiving care [and treatment] or services under this chapter involving a service-connected disability, such preventive health-care services as the Administrator determines are feasible and appropriate. In carrying out the pilot program under this subchapter, the Administrator may furnish such preventive health-care services to any other veteran described in section 612(f)(2) of this title.*

(2) In connection with preventive health-care services furnished under paragraph (1) of this subsection, the Administrator, in accordance with regulations which the Administrator shall prescribe, may institute appropriate controls and carry out followup studies (including research) to determine the medical advantages and cost-effectiveness of furnishing such preventive health-care services.

[(b) In carrying out the pilot program provided for by this subchapter, the Administrator may not furnish preventive health-care services after September 30, 1984.]

[(c)] (b) In carrying out this subchapter, the Administrator shall emphasize the utilization of interdisciplinary health-care teams composed of various professional and paraprofessional personnel.

[(d)] (c) In carrying out the program provided for in this subchapter, the Administrator may not expend more than \$10,000,000 in fiscal year 1980, more than \$12,000,000 in fiscal year 1981, more than \$13,000,000 in fiscal year 1982, more than \$14,000,000 in fiscal year 1983, or more than \$15,000,000 in each of fiscal [year] years 1984 through 1988.

#### **§ 664. Reports**

The Administrator shall include in the annual report to the Congress for each of fiscal years 1984 through 1988 required by section 214 of this title a comprehensive report on the administration of this subchapter, including such recommendations for additional legislation as the Administrator considers necessary.

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## CHAPTER 19—INSURANCE

### Subchapter I—National Service Life Insurance

#### § 719. National Service Life Insurance appropriation

(a) \* \* \*

(b) All premiums heretofore and hereafter paid on insurance issued or reinstated under [subsections] *sections* 602(c)(2) and 602(v)(1) of the National Service Life Insurance Act of 1940 where the requirement of good health was waived under such subsections because of a service-incurred injury or disability shall be credited directly to the National Service Life Insurance appropriation and any payments of benefits heretofore and hereafter on such insurance shall be made directly from such appropriation.

## PART III— READJUSTMENT AND RELATED BENEFITS

### CHAPTER 34—VETERANS' EDUCATIONAL ASSISTANCE

#### Subchapter IV—Payments to Eligible Veterans; Veteran-Student Services

#### § 1682. Computation of educational assistance allowances

(a)(1) \* \* \*

(c)(1) An eligible veteran who is enrolled in an education institution for a "farm cooperative" program consisting of institutional agricultural courses prescheduled to fall within 44 weeks of any period of 12 consecutive months and who pursues such program on—

(A) a full-time basis (a minimum of ten clock hours per week or four hundred and forty clock hours in such year prescheduled to provide not less than eighty clock hours in any 3-month period),

(B) a three-quarter-time basis (a minimum of 7 clock hours per week), or

(C) a half-time basis (a minimum of 5 clock hours per week), shall be eligible to receive an educational assistance allowance at the appropriate rate provided in the table in paragraph (2) of this subsection, if such eligible veteran is concurrently engaged in agricultural employment which is relevant to such institutional agricultural courses as determined under standards prescribed by the Administrator. In computing the foregoing clock hour requirements there shall be included the time involved in field trips and individual and group instruction spon-



sored and conducted by the educational institution through a duly authorized instructor of such institution in which the veteran is enrolled.

\* \* \* \* \*

## CHAPTER 41—JOB COUNSELING, TRAINING, AND PLACEMENT SERVICE FOR VETERANS

\* \* \* \* \*

### § 2002. Purpose

The Congress declares as its intent and purpose that there shall be an effective (1) job and job training counseling service program, (2) employment placement service program, and (3) job training placement service program for eligible veterans and eligible persons and that, to this end policies and regulations shall be promulgated and administered by [a] an Assistant Secretary of Labor for Veterans' Employment, established by section 2002A of this title, through a Veterans' Employment Service within the Department of Labor, so as to provide such veterans and persons the maximum of employment and training opportunities, with priority given to the needs of disabled veterans and veterans of the Vietnam era through existing programs, coordination and merger of programs and implementation of new programs.

### § 2002A. Assistant Secretary of Labor for Veterans' Employment

There is established within the Department of Labor [a] an Assistant Secretary of Labor for Veterans' Employment, appointed by the President by and with the advice and consent of the Senate, who shall be the principal advisor to the Department of Labor with respect to the formulation and implementation of all departmental policies and procedures to carry out (1) the purposes of this chapter, chapter 42, and chapter 43 of this title, and (2) all other Department of Labor employment, unemployment, and training programs to the extent they affect veterans. The employees of the Department of Labor administering chapter 43 of this title shall be administratively and functionally responsible to the Assistant Secretary of Labor for Veterans' Employment.

\* \* \* \* \*

## PART IV—GENERAL ADMINISTRATIVE PROVISIONS

\* \* \* \* \*

### CHAPTER 51—APPLICATIONS, EFFECTIVE DATES, AND PAYMENTS

\* \* \* \* \*

### § 3005. Joint applications for social security and dependency and indemnity compensation

The Administrator and the Secretary of Health and Human Services shall jointly prescribe forms for use by survivors of members and former members of the uniformed services in filing application for benefits under chapter 13 of this title and [subchapter II of chapter 7 of title 42] *title II of the Social Security Act*. Each such form shall request information sufficient to constitute an application for benefits under both chapter 13 of this title and subchapter II of chapter 7 of title 42; and when an application on such form has been filed with either the Administrator or the Secretary of Health and Human Services, it shall be deemed to be an application for benefits under both chapter 13 of this title and [subchapter II of chapter 7 of title 42] *title II of the Social Security Act*. A copy of each such application filed with the Administrator, together with any additional information and supporting documents (or certifications thereof) which may have been received by the Administrator with such application, and which may be needed by the Secretary in connection therewith, shall be transmitted by the Administrator to the Secretary; and a copy of each such application filed with the Secretary, together with any additional information and supporting documents (or certifications thereof) which may have been received by the Secretary with such form, and which may be needed by the Administrator in connection therewith, shall be transmitted by the Secretary to the Administrator. The preceding sentence shall not prevent the Secretary and the Administrator from requesting the applicant, or any other individual, to furnish such additional information as may be necessary for purposes of chapter 13 of this title and [subchapter II of chapter 7 of title 42], *title II of the Social Security Act*, respectively.

\* \* \* \* \*

## PART V—BOARDS AND DEPARTMENTS

\* \* \* \* \*

### CHAPTER 73—DEPARTMENT OF MEDICINE AND SURGERY

\* \* \* \* \*

#### Subchapter I—Organization; General

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### § 4104. Additional appointments

There shall be appointed by the Administrator additional personnel as the Administrator may find necessary for the medical care of veterans, as follows:

- (1) Physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and expanded-function dental auxiliaries;
- (2) Pharmacists, psychologists, [physical therapists,] occupational therapists, dietitians, and other scientific and professional personnel, such as [bacteriologists] *microbiologists*,

chemists, biostatisticians, and medical and dental technologists[.];

(3) *Certified or registered respiratory therapists, licensed physical therapists, and licensed practical or vocational nurses.*

#### § 4105. Qualifications of appointees

(a) Any person to be eligible for appointment to the following positions in the Department of Medicine and Surgery must have the applicable qualifications:

(1) **Physicians**—*Physician*

hold the degree of doctor of medicine or of doctor of osteopathy from a college or university approved by the Administrator, have completed an internship satisfactory to the Administrator, and be licensed to practice medicine, surgery, or osteopathy in a State;

(2) **Dentist**—

hold the degree of doctor of dental surgery or dental medicine from a college or university approved by the Administrator, and be licensed to practice dentistry in a State;

(3) **Nurse**—

have successfully completed a full course of nursing in a recognized school of nursing, approved by the Administrator, and be registered as a graduate nurse in a State;

(4) **Director of a hospital, domiciliary, center or outpatient clinic**—

have such business and administrative experience and qualifications as the Administrator shall prescribe;

(5) **Podiatrist**—

hold the degree of doctor of podiatric medicine, or its equivalent, from a school of podiatric medicine approved by the Administrator, and be licensed to practice podiatry in a State;

(6) **Optometrist**—

hold the degree of doctor of optometry, or its equivalent, from a school of optometry approved by the Administrator and be licensed to practice optometry in a State;

(7) **Pharmacist**—

hold the degree of bachelor of science in pharmacy, or its equivalent, from a school of pharmacy, approved by the Administrator, and be registered as a pharmacist in a State;

[(8) Physical therapist, occupational therapist, dietitians, and other personnel shall have such scientific or technical qualifications as the Administrator shall prescribe;

[(9) Physician assistants and expanded-function dental auxiliaries shall have such medical or dental and technical qualifications and experience as the Administrator shall prescribe;]

[(10)] (8) **Psychologist**—

hold a doctoral degree in psychology from a college or university approved by the Administrator, have completed study for such degree in a specialty area of psychology and an internship which are satisfactory to the Administrator, and be licensed or certified as a psychologist in a State, except that the Administrator may waive the requirement of licensure or certification for an individual psychologist for a period not to

exceed two years on the condition that such psychologist provide patient care only under the direct supervision of a psychologist who is so licensed or certified.

(9) *Physician assistant, expanded-function dental auxiliary, certified or registered respiratory therapist, licensed physical therapist, licensed practical or vocational nurse, occupational therapist, dietitian, microbiologist, chemist, biostatistician, medical technologist, dental technologist, or other position--*

*have such medical, dental, scientific, or technical qualifications as the Administrator shall prescribe.*

(b) Except as provided in section 4114 of this title, no person may be appointed in the Department of Medicine and Surgery [as physician, dentist, podiatrist, optometrist, nurse, physician assistant, or expanded-function dental auxiliary] *to a position listed in section 4104(1) of this title unless such person is a citizen of the United States.*

(c) Notwithstanding any other provision of law, no person may be appointed under section 4104(1) of this title after January 1, 1978, to serve in the Department of Medicine and Surgery in any direct patient-care capacity unless the Chief Medical Director determines, in accordance with regulations which the Administrator shall prescribe, that such person possesses such basic proficiency in spoken and written English as will permit such degree of communication with patients and other health-care personnel as will enable such person to carry out such person's health-care responsibilities satisfactorily.

#### § 4106. Period of appointments; promotions

(a) \* \* \*

\* \* \* \* \*

(g)(1) *The Administrator, upon the recommendation of the Chief Medical Director, may use (A) the authority in subsection (a) of this section to establish the qualifications for and, subject to paragraph (2) of this subsection, to appoint individuals to positions listed in section 4104(3), and (B) the authority in subsection (c) of this section for the promotion and advancement of Veterans' Administration employees serving in such positions.*

(2) *In using such authority to appoint individuals to such positions, the Administrator shall apply the principles of preference for the hiring of veterans and other persons established in subchapter I of chapter 33 of title 5, United States Code.*

#### § 4107. Grades and pay scales

(a) \* \* \*

\* \* \* \* \*

(f) Under standards which the Administrator shall prescribe in regulations[,], (1) physician assistants and expanded-function dental auxiliaries shall be compensated by use of Nurse Schedule grade titles and related pay ranges and shall be entitled to additional pay on the same basis as provided for nurses in subsection (e) of this section, and (2) notwithstanding any other provision of law, when the Administrator determines it to be necessary in order



*to obtain or retain the services of certified or registered respiratory therapists, licensed physical therapists, or licensed practical or vocational nurses, the Administrator may, on a nationwide, local, or other geographic basis, pay persons employed in such positions additional pay on the same basis as provided for nurses in subsection (e) of this section.*

(g)(1) Notwithstanding any other provision of law but subject to paragraphs (2), (3), and (4) of this subsection, when the Administrator determines it to be necessary in order to obtain or retain the services—

[(A) of physicians, dentists, podiatrists, optometrists, nurses, physician assistants, or expanded-function dental auxiliaries appointed under this subchapter; or]

(A) of individuals employed in positions listed in paragraphs (1) and (3) of section 4104 of this title; or

(B) of health-care personnel who—

(i) are employed in the Department of Medicine and Surgery (other than administrative, clerical, and physical plant maintenance and protective services employees);

(ii) are paid under the General Schedule pursuant to section 5332 of title 5;

(iii) are determined by the Administrator to be providing either direct patient-care services or services incident to direct patient-care services; and

(iv) would not otherwise be available to provide medical care and treatment for veterans,

the Administrator may increase the minimum, intermediate, or maximum rates of basic pay authorized under applicable statutes and regulations. Any increase in such rates of basic pay may be made on a nationwide, local, or other geographic basis, for one or more of the grades listed in the schedules in subsection (b)(1) of this section, for one or more of the health personnel fields within such grades, or for one or more of the grades of the General Schedule under section 5332 of such title.

(2) Increases in rates of basic pay may be made under paragraph (1) of this subsection only in order—

(A) to provide pay in an amount competitive with, but not exceeding, the amount of the same type of pay paid to the same category of health-care personnel at non-Federal health-care facilities in the same labor market;

(B) to achieve adequate staffing at particular facilities; or

(C) to recruit personnel with specialized skills, especially those with skills which are especially difficult or demanding.

(3) The amount of any increase under paragraph (1) of this subsection in the maximum rate for any grade may not (except in the case of nurse anesthetists and licensed physical therapists) exceed the amount by which the maximum for such grade (under applicable provisions of law other than this subsection) exceeds the minimum for such grade (under applicable provisions of law other than this subsection), and the maximum rate as so increased may not exceed the rate paid for individuals serving as Assistant Chief Medical Director.

(4) In the exercise of the authority provided in paragraph (1) of this subsection *with respect to health-care personnel described in*

*clause (B) of such paragraph* to increase the rates of basic pay for any category of personnel not appointed under this subchapter, the Administrator shall, not less ninety days prior to the effective date of a proposed increase, notify the President of the Administrator's intention to provide such an increase. If, prior to such effective date, the President disapproves such increase and provides the appropriate committees of the Congress with a written statement of the President's reasons for such disapproval, such proposed increase shall not take effect.

\* \* \* \* \*

#### **§ 4110. Disciplinary boards**

(a) The Chief Medical Director, under regulations prescribed by the Administrator shall from time to time appoint boards to be known as disciplinary boards, each such board to consist of not less than three nor more than five employees, senior in grade, of the Department of Medicine and Surgery, to determine, upon notice and fair hearing, charges of inaptitude, inefficiency, or misconduct of any person employed in a position provided in paragraph (1) of section 4104 of this title. [When such charges concern a dentist, the] *The majority of employees on [the] a disciplinary board shall be [dentists] employed in the same category of position as the employee who is the subject of the charges.*

\* \* \* \* \*

#### **§ 4111. Appointment of additional employees**

(a) There shall be appointed by the Administrator under civil-service laws, rules, and regulations, such additional employees, other than those provided in section 4103, [paragraph] *paragraphs (1) and (3) of section 4104, and those specified in section 4114 of this title, as may be necessary to carry out the provisions of this chapter.*

(b) *Notwithstanding any other provision of law, the Administrator may, after considering an individual's existing pay, higher or unique qualifications, or the special needs of the Veterans' Administration, appoint an individual to a position in the Department of Medicine and Surgery providing direct patient-care services or services incident to direct patient-services at a rate above the minimum rate of the appropriate grade.*

\* \* \* \* \*

#### **§ 4118. Special pay for physicians and dentists**

(a) \* \* \*

\* \* \* \* \*

(g)(1) \* \* \*

\* \* \* \* \*

(3) The President shall include in the Budget next transmitted to the Congress under section 1105 of title 31 [.] after the submission of each report of the Administrator under paragraph (2)(C) of this

subsection recommendations with respect to the exact rates of special pay for physicians and dentists under this section.

\* \* \* \* \*

#### Subchapter IV—Veterans' Administration Health Professional Scholarship Program

\* \* \* \* \*

#### § 4142. Eligibility; application; written contract

(a) \* \* \*

\* \* \* \* \*

(f)(i) A scholarship provided to a participant in the Scholarship Program for a school year under a written contract under the Scholarship Program shall consist of—

(A) payment to, or (in accordance with paragraph (2) of this subsection) on behalf of, the participant of the amount of—

(i) the tuition of the participant in such school year; and

(ii) other reasonable educational expenses, including fees, books, and laboratory expenses; and

(B) payment to the participant of a stipend of not in excess of \$485 per month (adjusted in accordance with paragraph (3) of this subsection) for each of the 12 consecutive months beginning with the first month of such school year, except that a stipend may not be paid to a participant who is a full-time employee of the Veterans' Administration and the stipend of a participant who is a part-time student shall be adjusted as provided in subsection (g)(2) of this section.

(2) The Administrator may contract with an educational institution in which a participant in the Scholarship Program is enrolled for the payment to the educational institution of the amounts of tuition and other reasonable educational expenses described in paragraph (1)(A) of this subsection. Payment to such an educational institution may be made without regard to *subsections (a) and (b) of section 3324 [(a) and (b)] of title 31.*

\* \* \* \* \*

(i) The Administrator shall report to Congress not later than March 1 of each year—

(1) the number of students receiving scholarships under the Scholarship Program and the number of students enrolled in each type of health profession training;

(2) the educational institutions providing such training;

(3) the number of applications filed, by health profession category, under this section during the school year beginning in such year and the total number of such applications so filed for all years in which the Scholarship Program has been in existence;

(4) the number of scholarships accepted, by health profession category, during such school year and the number, by health profession category, which were offered and not accepted [.,]; and

(5) the amount of tuition and other expenses paid, by health profession category, in the aggregate and at each educational institution for the school year beginning in such year and for prior school years.

\* \* \* \* \*

## PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

\* \* \* \* \*

### § 5010. Operation of medical facilities

(a)(1) \* \* \*

\* \* \* \* \*

(c)(1) \* \* \*

(2) The Administrator may enter into a contract under the circumstances described in paragraph (1)(B) of this subsection only if the Administrator determines—

(A) based on the study described in paragraph (4) of this subsection with respect to the activity involved, that the cost to the Government of the performance of such activity under such a contract over the first five years of such performance (including the cost to the Government of conducting the study) would be lower by 15 percent or more than the cost of performance of such activity by Federal employees; and

(B) that the quantity **[or]** *and* quality of health-care services provided to eligible veterans by the Veterans' Administration at the facility at which the activity is carried out would be maintained or enhanced as a result of such a contract.

\* \* \* \* \*